Virginia Medical Monthly

Vol. 74, No. 12
WHOLE No. 1146.

RICHMOND, VA., DECEMBER, 1947

$2.00 A YEAR
25 CENTS A COPY

MEDICAL PROGRESS DURING THE PAST CENTURY*

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We are often reminded that medicine has made more progress in the last fifty or sixty years than in all the preceding centuries. In preventive medicine, surgery, and therapy—the end-results of research that directly advance human welfare—this is certainly true. To make such an abstract statement meaningful, one has only to read case histories of the 1840's or even for as late as the '70's, wherein is revealed a type of practice that now seems bizarre, futile, and even dangerous. A so-called continued fever, which may have been typhoid, is treated by bleedings; a compound fracture indicates immediate amputation; an apparent case of appendicitis calls for purgatives, and then, if ("in spite of all that could be done") the patient becomes worse, morphine is "used as a last resort"! Read, for example, the dramatic accounts (given in Dr. Blanton's able *History*) of the care accorded wounded Confederate generals during the 1860's—care that presumably represented the best then available in the military services.

It is had to realize that all this was typical, not of some remote era, but of years within the lifetime of those still living! The revolution in medical science and practice which followed—apparently beginning about the 1880's—was a major transformation. How much more significant this was for all of us than were, for example, the ups and downs of Democrats and Republicans in national elections—to which latter story, by the way, historians give many times the space accorded to scientific progress. Some of our older physicians can actually recall the greater part of this medical revolution, and it is no mean thing to have participated in one of the great, sudden surges of human progress. We all know the main features of the story—the discovery of causal factors in infectious diseases; the implications of these findings for sanitation, for immunology, and for surgery; the impact of biochemistry through studies of endocrinology and nutrition; the remarkable transformation of professional institutions—of medical schools and hospitals—which responded to standards set by the new research; and then, finally, the achievements of recent years in chemotherapy. Truly, an old art and a most imperfect one has been metamorphosed over-night—as time goes—into a modern science.

Even the non-scientific public appreciates this. A century ago, American newspapers openly condemned the "ignorance" and "butchery" ascribed to physicians and surgeons; and the leaders of early state medical societies wrote melancholy papers on "the declining state of the medical profession". Today, one need only attend the "movies" to observe the popular appreciation of physicians and medical science; witness the adventures of the late-lamented "Dr. Kildare", or such pictures as "Pasteur" and "The Magic Bullet". Or consider the decline of the rival medical sects, which in the days of widely-patronized Thomsonian or homeopathic practice, really threatened the whole status of the regular profession. Only vestiges of these competing systems now remain, in such forms as osteopathy, chiropractice, and "Christian Science". Public criticism of the medical profession persists, indeed is more vocal now than it has been since 1880; but note that lay critics are no longer skeptical about medical science. Their only protest is that, as some believe, they cannot get enough of the medical care that science has made possible. Even the ignorant person can appreciate the specific help given him in illness; while the well-educated are

*Read by invitation at the 100th meeting of the Medical Society of Virginia in Roanoke, October 13-15, 1947.

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conscious not only of the near-disappearance of many infectious diseases but also of the amazing net result; namely, that the average life expectancy of Americans at birth has about doubled within a century.

Just because these achievements are so remarkable, however, present generations need to be warned against complacency. I need not remind you that scientific problems still confront us—problems as sinister as they are complicated. The fact must be faced, that certain chronic and degenerative diseases seem to have increased almost in inverse ratio to the decline in communicable disorders. One can imagine a physician of fifty or perhaps only ten years hence marveling at our limitations in confronting, say, hypertension; even as we now wonder at the ignorance of 1850 in the presence of typhoid or of yellow fever. Yet we have at least this advantage today, that we know the methods of research which must be employed—controlled experiments, improved instruments of observation, statistical procedures and so on—which must be used in the advance against the still untaken bastions of disease. More than this, we know—or at least believe we know—the weakest points to attack; that is, we have some understanding of what questions to raise, of what approaches to follow.

Medical scientists of a century ago only partially comprehended the questions they had to ask of Nature, or, more specifically, of the human body and its environment. And they were only beginning to appreciate the methods which are now taken for granted. It may be assumed that they were just as intelligent as we, perhaps even a bit ahead of us in this respect. Why, then, was their progress apparently so slow prior to 1880? The answer is partly social rather than scientific in nature; for example, one could not really test the efficacy of a therapeutic procedure without clinical statistics and "controls"; these were not available until large modern hospitals were built, and the latter in turn had to await the growth of great cities after 1800. The explanation also lay partly with the rate of advance in other sciences. To use the same illustration, full use of clinical statistics depended on the development by mathematicians of the calculus of probabilities, which did not occur until about 1800. Or to cite a more obvious instance, medical bacteriology had its advent as early as 1650, but could make little headway until the achromatic microscope was evolved during the 1820's.

Although retarding factors of a social or technical nature were serious, the most potent factor in the long lag in medical progress before 1880 lay with medical men themselves. And this was simply the fact that they, in studying illness, had for centuries asked the wrong questions. They were always inquiring: how can we prevent disease or cure it? What was more natural: was that not what everyone wanted them to discover? Yet we can now see that no rational search for remedies could be made until the diseases themselves were first discovered. How find cause or cure for typhoid, when the doctor never knew whether he was dealing with what would now be termed typhoid, or typhus, or malaria, or other infections that cause fevers?

It was only when this concept of disease specificity gradually evolved in medical minds between 1650 and 1800, and when men attempted to distinguish systematically between one disease and another, that modern medicine loomed on the scientific horizon. Once the need for disease identification was realized, the question arose, what are the criteria for such identifications? The first and simplest was that of symptoms—which is almost all we have today in such a condition as the common cold. But symptom complexes were innumerable and confusing; hence, the doctor of 1847 talked as though different diseases were indicated by such symptomatic classifications as "intermittent fever," "continued fever," "jail fever," "putrid fever," "yellow fever," and so on. The second criterion discovered was that of pathologic lesions which, when correlated with symptoms, gave a far clearer picture of disease entities. Such a correlation, for example, broke down the old symptom picture of "inflammation of the chest" into the fairly well-defined concepts of "pneumonia," "pleurisy," "bronchitis," and so on.

This pathologic research was followed by the Italian Morgagni by 1750, and was pursued systematically by French and Austrian clinicians between 1800 and 1850. It was introduced into the United States by students returning from Paris after 1820; but little such work was done in this country prior to 1880—partly because of popular prejudices against dissection, partly because the practical Americans would not support research that led to no immediate prevention or cures. Gerhard,

of Philadelphia, showed by autopsies in 1837, the difference between typhoid and typhus; but who cared as long as he found no cure for either condition? On the other hand, Americans did excellent work when practical results were in view; witness their clinical research in the development of surgical anesthesia during the 1840's.

Yet to the early nineteenth-century pathologists, we owe the real advent of modern medicine. Toiling at difficult and unpleasant autopsies and correlating their findings with the ante mortem clinical data, they had worked out by 1850 the broad features of modern disease identification. Of course they strove to improve the exactitude of clinical observation as well as of dissections; hence the appearance of the stethoscope during the 1820's and gradually, thereafter, of all the other 'scopes now employed. To these men we owe modern medicine, rather than to the Pasteurs and Kochs of the 1880's—valuable as were the services of the latter. Pasteur and Koch reaped where the earlier pathologists had sown. For, be it repeated, no one could have sought the causes or cures of anthrax, or typhoid, or tuberculosis until those entities had been discovered and defined.

The pathologists worked without public acclaim, for they helped no patients in their generation. Theirs was the realm of pure science, and there is no better illustration of the value of pure science than what they achieved. Indeed, they even went to the extreme of nihilism; that is, they lost interest in therapy as such. (This was one reason the public lost faith in medical science by 1840, and turned to the cults which promised all things to the sick.) Today, it is hard to convince even physicians of what we owe to these pure scientists, to such leaders as Louis and Laennec in France, Bright in England, Rokitansky in Austria, and Gerhard in the United States. Nor can we dramatize them to the public today, as we do Pasteur or Ehrlich, since they worked only at the autopsy table. Not even Hollywood could make a movie thiller in which the main character was the cadaver!

Just how did disease identification lead to all the so-called "triumphs of modern medicine" that ensued after 1880? One practical result appeared even as early as the 1840's, namely, the emergence of new opportunities and techniques in surgery. We usually assume that surgical progress resulted from the discovery of anesthetics and later of antiseptic procedures. Actually, as Dr. Sigerist pointed out some years ago, it was the emphasis upon pathologic anatomy—upon the relation of structural lesions to specific diseases—that led to the new surgery. As long as pathology consisted only of theories about impure blood or nervous tensions, there was no place for surgery except for emergency measures. How could one operate for a disease caused by "impure blood," anymore than we can now operate for septicemia? But as soon as diseases were associated with specific parts, then the removal of the latter promised cures. And so surgery moved from the periphery to the center of medical practice.

But the major explanation of how pathology made possible all later progress in medicine has already been suggested. Once you knew just what typhoid fever was, then it was possible to seek its cause or cure. If a disease was specific, its cause was likely to be specific. For centuries before 1840 there had been two theories as to how communicable diseases spread: (1) by poisons in the surrounding atmosphere (noxious miasms), or (2) by living organisms (*contagium vivum*). After 1840, there were many efforts to find specific poisons in the air which could cause specific diseases. These proved fruitless. Meantime, there were also attempts to check the other theory by isolating specific organisms (animalculae) which could cause specific diseases. These efforts were rewarded after 1870, as we all know, by the discovery of pathogenic bacteria—an achievement also made possible by the microscope and by Koch's improvements in bacteriologic techniques.

Note that medical bacteriology not only soon led to antiseptic surgery, to a science of immunology, and eventually to an effective chemotherapy, but that it also advanced disease identification and therefore diagnosis to a third and most effective level. To the criteria of symptoms and of lesions, could now be added that of cause. Throat symptoms and even lesions may look like diphtheria, but a case is no longer diagnosed as such unless the specific organisms are present. How important it is to identify a disease by its etiology as well as by the other criteria, may be seen in the degree of control we have over a condition known by all three tests—such as diphtheria—as compared to one which is known only by symptoms and lesions

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(as in nephritis) or only by symptoms alone (as in the cold).

When did American medicine join in this triumphant scientific procession? Until about 1890 it largely followed in the rear, taking over its science from France until about 1860, and from Germany thereafter. Basically, as noted, the lag in American research can be ascribed to the fact that we were a practically-minded people concerned largely with the end-results of research. This was not because the United States was "a new country," or because it lacked either the population or wealth to advance medical science had its people so desired. During the War Between the States, military surgeons amassed the greatest collection of pathologic data available anywhere in the world but did relatively little with it. Prestige in the American medical profession lay in successful practice, since this seemed practical and also led to income that accorded social standing. Research that had no bearing on cures, on the other hand, seemed impractical, brought no wealth, and so was tolerated rather than supported by either government or private philanthropists.

In my opinion, the American people have not changed in this regard: we still seek that which is practical and we still cultivate efficiency. Do not let us under-estimate these attitudes, by the way, for there is much to be said for them. The very Europeans or Latin-Americans who ridicule our so-called "materialism" are quite glad to take over our practical technology, or to seek the financial aid which is made possible only by our combination of commercialism and generosity. But the fact remains that our national attitudes did not encourage the support of pure research before 1890. How, then, explain the sudden appearance of first-class medical science in this country after that time?

If Americans did not change, two other factors did. First, the discoveries of Pasteur's day revealed for the first time a type of basic research that *did* lead almost immediately to practical results. Immunizing vaccines and serum therapy were very practical and Americans sought them avidly. Pasteur's work was barely under way before such Americans as Sternberg were making similar studies; within a few years certain of our fellow-countrymen were abreast or even ahead of European contemporaries. This can be seen in Theobald Smith's pioneer discovery of the insect vectors of certain infections. After 1900, American sanitary engineering—based now on bacteriology as well as on mathematics—became as good or better than that of any other land. And we all know of the amazing progress of our native surgery during the Mayo era. Today, even the most basic cancer studies seem to be based here on the conviction that, after all, such research will really prove the quickest way to secure useful results.

One other factor changed in this country, which also aided in placing American medical science in the van of world progress after 1914. This was simply the accumulation of great wealth, based on natural resources and on a superior technology. While some wealth was always necessary to support science, all the medical progress that has been noted rapidly made medical research—as well as medical practice—far more expensive than it had ever been before. The pathologist of 1850 needed as equipment only a table, washstand, a few chemicals and a surgical kit; while the clinician called only for some drugs, a lancet, and a stethoscope. Compare this with the elaborate and expensive equipment now required in medical laboratories or even in the wards. It was what the old astrologers would have called an "angelic conjunction," that just when medical science became ever more costly, American institutions became ever more wealthy. Of course, medical faculties always feel that their schools are short of funds; but compare their situation with that of many European institutions. The recent war has made this contrast more glaring. Next year, the medical school of Padua—one of the historic seats of early medical progress—will have just fifteen dollars available for the purchase or repair of microscopes. Ten or twenty students must use the same instrument.

Relatively, then, American medical science stands today in a position of unique advantage. It is our task, perhaps more than that of any other single nation, to carry the torch of medical discovery which has been handed on by great European predecessors. The realization of this situation should lead, not to national complacency, but to a determination to be worthy of this grave responsibility.

EIGHTEEN HUNDRED AND TWENTY
The Virginia Doctor and His Times.*

WYNDHAM B. BLANTON, M.D.,
Richmond, Virginia.

Mr. President, Ladies and Gentlemen:

Tonight, in celebration of a centennial, it is my pleasant task to talk about the Medical Society of Virginia and its origins. Although one hundred and twenty-seven years have elapsed since our society's founding, not until today have we held our one hundredth meeting.

I.

Let us imagine this is not October 13, 1947, but October 13, 1820, the year we were founded. It is Friday—Friday the thirteenth. What the state of the weather was, I do not know. The first records of weather in Richmond were kept by the R.F.&P. Railroad — but not until after 1872 — and the Weather Bureau was not established there until 1897. For the place is Richmond—and it is the day after the fair. The place might have been Roanoke, now the third largest city in our Commonwealth, had Roanoke been in existence; but I must remind you that it was 1884 before the name Roanoke was applied to this community, and that the antecedent name "BIG LICK" was not used until 1834. In 1820 the chief person living in this neighborhood was one Kemp Gaines, and he was not interested in founding a medical society.

One hundred and twenty-seven years ago, 90% of the nation's population lived in the country, only 10% in cities. Certainly Richmond was then not much of a city in terms of modern values. There 4,000 Negro slaves served 6,000 white masters and 1200 free negroes wondered what it was all about. Most of the houses were small and unpretentious. The more imposing were surrounded by numerous necessary outbuildings. Cobblestones were just coming into vogue as a cure for dusty, muddy streets. There was no railroad, but a steamboat made a journey to Norfolk luxurious and exciting. Other travel, when not on foot, was by horseback, chariot or stage.

The City Directory for 1819 listed twenty-eight physicians, approximately one for every 400 of the population, nearly twice as many per thousand as are now in the United States (1-760).

Here it should be stated that it was 1851 before the Medical Society of Virginia became in fact a state-wide organization, although it bore this name from the first, as the founders hoped to attract to its membership doctors from the state at large. This was, however, too much to expect at a time when, although Virginia had a population of over a million people and her western borders stretched to Pennsylvania, Ohio and Kentucky, there were no railroads and it took seventeen hours to get from Fredericksburg to Richmond.

II.

What was the world of our founders like on the thirteenth day of October, 1820? Of course the sun rose at 5:53 A.M. and set at 5:07 P. M., just as it did today. There were other similarities. Europe was prostrate from the Napoleonic wars. England had won the war, but not the peace. The trade of the world was in her grasp but she faced a staggering debt. Commerce and profiteering had brought great wealth to some but the masses were pitifully poor. It was a time of social unrest aggravated by unwise legislation. The nation was making the painful transition from an agrarian to an industrial economy while a powerful parliamentary block sought subsidies for the farmer who could not make a go of it.

For America it was a year of decision—the year of the Missouri Compromise. Then and there the issues of '61 to '65 were drawn and many Virginians were not unaware of the inevitable *dies irae* ahead. Remember that Jefferson, Marshall, Madison, Webster, Calhoun and Clay were still alive. Monroe was president of the United States; Thomas Mann Randolph, Governor of Virginia. James Barbour and James Pleasants were in the Senate, John Randolph of Roanoke was as vituperative as ever. Richmond's Mayor was a doctor.

Perhaps the average Virginia doctor was too busy with his profession to take in the political significance of what was transpiring. Perhaps he found it more relaxing to lend a half-attentive ear to his wife's enthusiasm for the New York weekly, *The Ladies' Literary Cabinet*, or for Scott's Ivanhoe, just off the press. It is true that only one-half the

*An Address delivered, by invitation, before the Medical Society of Virginia, at its annual meeting in Roanoke, October 13-15, 1947.

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women of the period could read or write, but no doubt a doctor's wife, then as now, was an exceptional woman. So there was more than a fifty-fifty chance of her being able to tell him what was going on. Assuming that his was a literary family, it had other subjects for discussion, for Byron, Coleridge, Keats, Shelley and Wordsworth were busily packing beauty and truth—each into his own chosen literary vehicle.

Whittier, Holmes, Longfellow, Hawthorne, Poe and Emerson were still boys. Washington Irving was in Europe. William Cullen Bryant was only twenty-six years old, but he had already written *Thanatopsis* and *To a Water Fowl*. Obviously if the literary appetite of our doctor was to be satisfied he had to depend upon foreign, rather than domestic fare.

Two newspapers are now published in Richmond. On this day 1820, with a population one-seventeenth as large, the town offered no less than three dailies. If one is in search of a mirror of contemporary life there is no more rewarding place to seek it than in the advertisements that occupied so prominent a part of the newspaper of the early Nineteenth Century.

A glance at the *Richmond Enquirer*, the *Richmond Compiler* or the *Virginia Patriot* for October 13, 1820, is not disappointing. On this day there were offered for sale to the citizens: buildings, land, ready-made clothing, grate coal, rum, gin, cheese, drugs, a few firkins of mountain butter, green coffee, salt filled in Liverpool, forty kegs of gunpowder, mahogany furniture, and four negro men.

There was a time table for sailing vessels. The steamboat "Pocahontas" advertised its run down the James River to Norfolk. The Virginia Museum wanted everyone to see a large oil painting of Christ appearing to Mary Magdalene. There was an announcement of the "fifteenth class of the seven numbers lottery to be drawn in the city of Richmond on the eighteenth day of November next." Someone wanted the services of a young man from sixteen to nineteen years of age "who stood well in the art of penmanship." The Richmond troop of cavalry announced a parade for the next Saturday. One John Burns, lately arrived from Europe, solicited private pupils. One death and one marriage were recorded for the day. There were the usual letters to the editor.

Foreign news was entirely concerned with the English Queen Caroline's trial for adultery which her adulterous husband King George IV was pushing in Parliament. Under domestic news, considerable space was given to an article on respiration and the circulation of the blood by a Dr. Carson who had actually experimented on a number of animals, including the ox, the cat and the rabbit. Scant attention was paid to the national scene. A border exploring expedition had just returned to Detroit, and the commission appointed under the Treaty of Ghent to settle the boundaries between the United States and the British Colonies had just submitted its report. Some notice was given to the bank of the United States and there was a brief article on the public lands.

III.

Our Virginia doctor of 1820, although he wore his hair long, was clean shaven. He dressed in a plain cutaway, ate with his knife as the notion struck him, occasionally took snuff, and had never heard of a calling card or a dinner jacket.

A brief tour of observation around his premises might take us into his stable to admire two or more saddle horses, ready, not for a fox hunt, but for a day of hard riding, or for a turn in the jumper. Our doctor was not a man of affluence and leisure. Bills for his services were hard to collect from an often unfriendly public.

In his office Abernethy's *Surgery* might catch our eye, as would, perhaps, Barton's *Materia Medica*, Bell's *Surgery*, Burn's on *Obstetrics*, Cheyney *on the Larynx and Bronchi*, Cullen's *Practice of Physic*, Haighton's *Midwifery*, Rush's *Works*, the *London Pharmacopoeia*, Scarpas' *Surgery*, Triplett on *Apoplexy*, and Underwood on *Children*.

A peep into his saddle bags would reveal no instruments of precision, not even a stethoscope or a thermometer, but there would be lancets, scissors, tweezers, needles and thread, a saw, a seton, scarifiers and cups, a blistering plaster, Dover's powder, ipecac and opium pills, and laudanum, jalap, senna, rhubarb, calomel and salts, castor oil, antimony, Black Wash and the bark.

In 1820 the large slave population of Virginia provided a considerable part of the practice of the average physician. It is noteworthy that the slave owner carried heavy investments in his slaves and, aside from any humanitarian considerations, wanted to take no risks of their sickness and death. Slave

practice was common, lucrative and of a superior order.

It is to be remembered that our doctor was a general practitioner. He had not contracted the itch to specialize. He believed in a humoral theory of medicine, and knew little of organ pathology or specific disease. He did his own social service work, and practiced psychosomatic medicine daily. When we recall that probably 80% of modern medicine is concerned with the psyche, the field of usefulness of the good physician in 1820, in spite of his lack of penicillin and the sulfonamides, was by no means as restricted as some are inclined to believe.

IV.

In 1820 this country was not plagued by the hosts of proprietary medical colleges which later carried medical education into such disgrace. At that time the prospective medical student had a choice of eight good schools. There were none in Virginia, and only one in the South (Transylvania). Virginians usually went to the University of Pennsylvania, the oldest and most renowned. The apprenticeship, of course, was still in vogue, and the majority of doctors got their training through this old but imperfect system.

The Virginia doctor in 1820 had access to only four native medical journals—all that were published in America. These were the ephemeral *Medical Repository* and the short-lived *American Medical Recorder; the New England Journal of Medicine and Surgery;* and, what has since become our oldest and most aristocratic medical publication — the *Philadelphia* now the *American Journal of Medical Sciences*. The last two were not unlike in their emphasis on what was calculated to appeal to the average doctor in a rural community with an interest confined to practical matters. The case history, obstetrics, the newest use of such drugs as mercury, prussic acid, arsenic, silver nitrate, the medicinal virtures lately discovered in our indigenous plants—this is what was to be read that year in these journals.

Of particular interest to Virginians was the *Philadelphia Journal of Medical Sciences*—then in its first volume. It was edited by Nathan Chapman, who had been born in Fairfax County, Virginia. Professor of the Institutes and Practice of Medicine in the University of Pennsylvania, and star attraction for Southern medical students, Chapman was destined to become the first president of the American Medical Association. Especially pleasing to the Virginia doctor, thumbing the pages of this newest medical publication on the thirteenth day of October, 1820, was Chapman's dedication of the volume to James McClurg, of Richmond, whom he called "an illustrious citizen of my native state."

It might be of interest in this centennial year to speculate on the physicians our Virginia delegates would have encountered from other parts of the country had the American Medical Association been organized in 1820 instead of twenty-seven years later. In all likelihood there would have been in attendance, besides Chapman, two other native Virginians: William Horner and Ephraim McDowell. From Boston would have come Warren, Gorham, Channing, Bigelow, Jackson, and Waterhouse; from Philadelphia, besides the two Virginians just mentioned, Gibson, Coxe, James, Barton, and Physick —the latter talking about his improved use of the snare in the removal of tonsils and hemorrhoids; from New York, Hosack, Mitchell, Dewitt, Post, Bard, Smith and Valentine Mott who had just tied the innominate artery; from Kentucky, Dudley, Brown, Caldwell and Nathan Smith. Perhaps William Beaumont would be there. He had not yet met Alexis St. Martin, but was already endowed with the scientific spirit. Daniel Drake could have been counted on, and Horatio Jameson who this very year had won a great reputation for resecting the superior maxilla.

V.

I must ask you now to exercise your imagination again. It is still 1820, but the day is December 15th. On this day seventeen physicians of Richmond and Manchester met to form themselves into a society to be styled the Medical Society of Virginia. Three dominant ideas were in the minds of the founders of all early medical societies: (1) the improvement in medical education—then at a very low ebb: (2) the placing of a quietus on professional rivalry and quarrels through the evolution of codes of ethics; and (3) the control of the charlatan through the standardization of medical fees. The preamble of the constitution our founders were to write declared that "the good people of this Commonwealth heretofore suffered great inconvenience and injury from an almost exclusive dependence on foreign institutions for instruction in the principles

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of this essential branch of knowledge; that the character and best interests of the state require that the evils of such dependence should as far as possible be removed by the introduction of institutions of our own; and that an association, having in view this object long so highly prized and so anxiously expected by its liberal minded inhabitants is now deemed practicable."

To this was added a resolution that speaks for itself: "No person holding in part or whole any patent medicines or remedies for disease shall be eligible to a seat in this society." Our forebears in 1820 were spared homeopathy, osteopathy, and chiropractics. Eclecticism, Thomsonianism, Mesmerism, were cults of the future and had not raised their ugly heads. Nevertheless, there were irregular practitioners a plenty. In 1847 for example, of 972 Virginia doctors in 74 of 119 counties, 249 held no diploma, a proportion of one in four.

We do not know all the seventeen founders of the society. We have only the list of incorporators to guide us. We do know that Virginia's most eminent and venerated physician, James McClurg, was elected its first president. He had been educated at William and Mary and at Edinburgh, had been an officer in the Revolutionary Army, and the only professor of anatomy and medicine in William and Mary College. He had moved to Richmond where he gained professional and political prominence. He was a friend of Washington, and at one time he was mentioned for Secretary of State.

James Henderson was the vice-president. He was a Scotsman, who had moved from Amelia County to Richmond to acquire a large and lucrative practice. He was destined to become the third president of the society. The list continues with William Foushee, Edinburgh graduate and Revolutionary soldier, who had come up from Norfolk to become the town's first Mayor. After him one of Richmond's well known streets is named. He was the society's second president. Following him in the list is the name of James Brown McCaw, commanding officer of the Chimborazo Hospital during the Civil War, and grandfather of Walter D. McCaw, a brigadier-general and once chief surgeon in the Philippine Islands.

The roll continues with the names of George and Robert H. Cabell. One of the Cabells and their kin, James Lawrence Cabell, made history later at the University of Virginia. George Watson was educated at William and Mary, at the University of Pennsylvania, and Edinburgh. He was to serve on the town's Board of Health. His library is now owned by the Richmond Academy of Medicine; John Hayes had been an officer in the War of 1812; and Micajah Clark, apprenticed to John Adams, later a Pennsylvania graduate, was called by Dr. Physick "a born physician." There were Thomas and Nathaniel Nelson, and William A. Patteson who had moved to Richmond from Petersburg. He had invented a method of vaginal hysterectomy which was highly regarded. He was three times president of the society.

The list concludes with James Blair, founder of a drug store in Richmond that is still thriving; William H. Henning, a Revolutionary surgeon; James Worrall, an ardent believer in phlebotomy; John Adams, an early Mayor of Richmond, after whom one of her present streets is named; Lewis W. Chamberlayne, Pennsylvania graduate, who lived outside of Richmond at "Montrose," one of the founders of the Medical College of Virginia and its first professor of Materia Medica; R. L. Bohannan, also a graduate of Pennsylvania, a founder of the Medical College of Virginia, first professor of obstetrics; R. A. Carrington; John Dove, founder of Dove Lodge, whose Hollywood monument is one of the largest and most imposing in the cemetery; Branch T. Archer; William Tazewell; Edward H. Carmichael, and Philip Augustus Klepstine.

As one reads the record, one is impressed by the number of these men who studied at the University of Pennsylvania and at the University of Edinburgh. Some were young men; some were old men. A number had been in the Revolutionary Army; six had served in the War of 1812. Many attained the highest political recognition.

To such men, tonight, we grant the immortality of remembrance, confident that another hundred years will see more astonishing advances in medicine than we dare dream of, even in this year of atomic fission with all it promises if (controlled) for scientific progress and for human betterment.

828 West Franklin Street.

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Medical Society of Virginia Cancer Committee

Chairman, GEORGE COOPER, JR., M. D.
Room 383, Medical School Building, University, Virginia

Reprints of this and preceding Bulletins may be obtained from this office
December 1, 1947

Tumors of the Central Nervous System

In so far as early diagnosis is concerned, distinction between benign and malignant tumors of the central nervous system can and should be disregarded. Early recognition is equally important and the initial treatment the same—surgical removal.

Delay in diagnosis increases operative risk and *permits irreparable damage* to the delicate nervous tissue, with such sequelae as permanent loss of vision and loss of motor and sensory function, *even though the tumor can be completely removed.*

DIAGNOSIS

A 28 year old man was hospitalized, complaining of progressive loss of vision, headaches, and weakness of the left side of the body of about six months duration. For the the past TWO YEARS, the patient had had convulsions which always started in the left foot. At operation a large tumor was removed from the right cerebrum. The weakness in the left side of the body disappeared but the patient DID NOT RECOVER HIS VISION.

The symptom complex of headache, nausea, vomiting, and papilladema is *not* early evidence of the presence of a brain tumor. It is evidence that increased intracranial pressure has been produced by a space consuming lesion within the skull. A hopeful prognosis and low morbidity can be achieved only if tumors are recognized and removed *before* they have caused increased intracranial pressure.

In the presence of any *one* of the following,

(1) repeated, unexplained attacks of vomiting in children,

(2) headache of progressive severity in either children or adults,

(3) convulsions after the age of 25, and

(4) progressive loss of vision at any age,

a brain tumor should be suspected and a neurosurgeon consulted.

A 36 year old man was admitted with paraplegia of five days duration at the sixth thoracic level. Motor and sensory loss were complete and the sphincters paralyzed. The legs had been weak and numb for one week before admission. He had had upper dorsal girdle pain for TWO MONTHS and pain in the upper dorsal spine for THREE MONTHS. Operation immediately after admission revealed a tumor which was completely removed from the spinal canal. The patient recovered from surgery nicely, but THE PARAPLEGIA PERSISTED.

Paralysis is *not* early evidence of a spinal cord tumor. In the presence of one or more of the following,

(1) unexplained back pain,

(2) root pain,

(3) progressive weakness of one or more extremities, a cord tumor should be suspected and a neurosurgeon consulted.

In fact, tumor is the first consideration in the presence of slowly progressive impairment of any central nervous system function.

COMMENT: Central nervous system tumors are neither rare nor hopeless. *Over 60% can be completely removed. The operative mortality is just under 10% and still declining.* In the tumors that can be completely removed, the surgical result depends entirely on how much nerve tissue damage has been done—on how promptly the presence of a tumor was recognized.

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ACUTE PERIPHERAL ARTERIAL EMBOLISM AND THROMBOSIS*

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One of the attractions of our chosen profession is its non-static nature. New theories, new armamentarium constantly force us to review old subjects. Thus the new drugs, heparin and dicoumarin, making practical, anticoagulant therapy, necessitate a revision of an old subject—arterial embolism and thrombosis. For the chief causes of failure of therapy in pre-anticoagulant days were secondary thrombosis at the site of the embolectomy if surgery was attempted, and the rapid formation of the tail thrombus distal to the embolus. Early diagnosis, effective anticoagulant therapy can prevent the formation of the tail thrombus and greatly reduce the incidence of secondary thrombosis after embolectomy. The changed prognosis is well illustrated in a current report of five consecutive successful aortic embolectomies by Murray. Murray credits to heparin his good results. Nystrom reports a case in which he twice performed arteriotomy and embolectomy, only to be foiled by secondary thrombosis, and then reopened the artery for the third time and injected heparin with a perfect result.

ETIOLOGY OF PERIPHERAL EMBOLISM

The common causes of emboli large enough to occlude the major arteries of the extremities are rheumatic heart disease, arteriosclerotic heart disease, and coronary infarction. The heart is often fibrillating or decompensated. In addition to the heart, peripheral embolism may result from thrombi deposited on atheromatous plaques of the aorta or rarely from venous thrombi swept into the arterial system through a patent foramen ovale.

SYMPTOMS AND SIGNS

The cardinal symptoms and signs of peripheral arterial embolism are sudden pain in the extremity, followed by pallor and coldness of the part, loss of sensation, inability to use the part, absence of arterial pulsation, collapse of the cutaneous veins and, finally, cyanotic discoloration, indicating impending gangrene. Pain may be entirely absent until a large amount of muscle becomes ischemic—several hours after the lodgment of the embolus. The greatest pain may not be at the site of occlusion, as illustrated by the severe pain in the knee in embolism at the femoral bifurcation.

*Read before a recent meeting of the Norfolk County Medical Society.

LOCATING THE SITE OF THE OCCLUSION

1. When an embolus is lodged at the bifurcation of the common femoral a pulsation is present in the common femoral at the inguinal ligament level. Just below, all pulsation is absent.
2. When the occlusion is above the inguinal ligament, or in the iliac artery or the aortic bifurcation, no pulse is felt at the inguinal ligament level or below.
3. Usually proximal to the embolus there is an excessively prominent pulsation of the artery, as in an amputated stump; actually a pulse may be felt several cm. distal to the obstruction due to pulsation transmitted by the clot itself.
4. Skin temperature changes are fairly diagnostic. The level of the change from cold to warm skin is above the ankle in popliteal occlusion, just above or below the knee in occlusion at the femoral bifurcation and in the upper third of the thigh in iliac occlusion.
5. The oscillometer is helpful in locating the occlusions below the femoral bifurcation.

The majority of emboli occur in the femoral and iliac arteries or at the bifurcation of the aorta. The most frequent site of localization is the lower femoral artery. The next common site is at the branching of the common femoral and profunda femoris. The point of lodgment is usually where the major vessel branches—as the thrombus encounters vessels of narrower lumen. Determination of the position of the embolus is not difficult. Extreme tenderness over the region of occlusion may be present, but is a late sign. The exact point is determined by noting the level at which arterial pulsation is still present and the point at which arterial pulsation is no longer palpable. In the lower leg, popliteal region or lower thigh the oscillometer will help demonstrate the site

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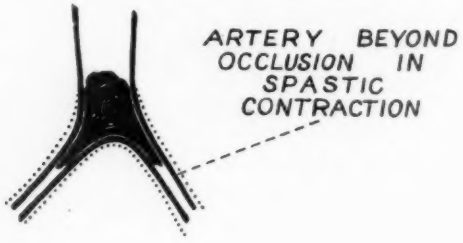
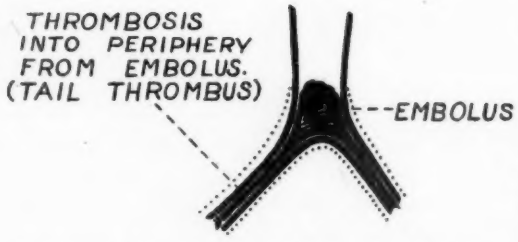
of occlusion. A full bounding pulsation, as in an amputation stump, may also be present in the artery just proximal to the occlusion. Thus, when the embolus had lodged at the bifurcation of the femoral artery, a vigorous pulsation of the common femoral may be palpable a little higher at the inguinal ligament level. A few centimeters lower in the thigh, no pulsation is felt. When an embolus has lodged at the bifurcation of the aorta no pulse is felt at the inguinal ligament level on either side. Changes in the skin temperature furnish supporting data. The line at which the temperature of the skin changes from low to normal is located just above the ankle in occlusion of the popliteal artery and at the junction of the lower and middle third of the thigh in





occlusion at the bifurcation of the femoral artery. When the common iliac artery is occluded the point of skin temperature change is located at about the junction of the middle and upper third of the thigh.

In a fair proportion of cases, immediate symptoms and signs may suggest complete obstruction at the aortic bifurcation, but under observation for a few hours the findings change, indicating that what was originally a thrombus impacted at the bifurcation has broken up and slipped down one or both sides to a lower level. The clinical picture may then be that of a bilateral femoral or popliteal occlusion.

Sometimes, small emboli may pass into the periphery and initiate immediate vasospastic phenomena and temporary symptoms and signs of arterial deficiency which subsequently disappear more or less completely.

The Course of Events—The Role of Spasm

Spasm is an important element of all instances of arterial embolism. Spasm of the artery beyond the occlusion prevents the embolus from descending further in the arterial system, and thus serves a useful purpose. There is unfortunately concomitant spasm of the related arterial collaterals preventing channeling of the blood around the site of embolic occlusion. The course of events in arterial embolism may be described as follows: The embolus lodges at a point of bifurcation, assumes the shape of and occludes the lumen of the vessel. The branching artery beyond the occlusion goes into spastic contraction. Spasm of the collaterals further diminishes the volume of blood entering the artery beyond the occlusion. Extensive thrombosis occurs from the site of embolus into the periphery—the so-called tail thrombus. Variations of the phenomena are many. At the aortic bifurcation the thrombus may be forced partly down each iliac, forming the so-called rider, or saddle thrombus. Or fragmentation of the thrombus may occur, large or small emboli passing down each iliac to the femoral.

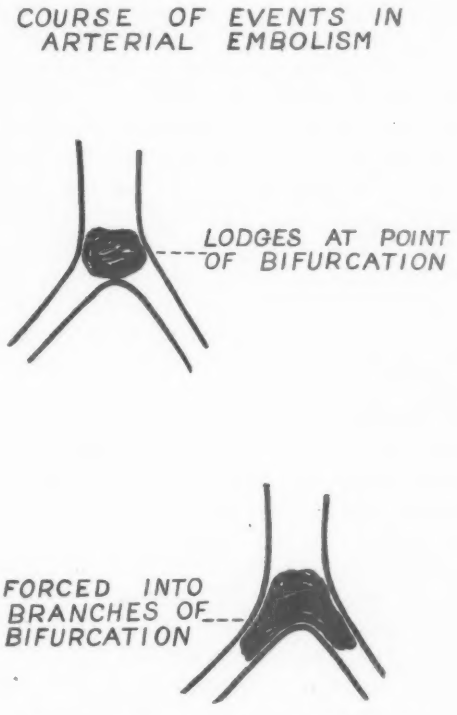
Arterial Thrombosis

Arterial occlusion may occur as the result of local thrombosis rather than embolism. This is not uncommon in arteriosclerosis obliterans, thrombo-angiitis obliterans and in a cardiac decompensation. Nygaard and Brown in 1937 described five cases of simple idiopathic arterial thrombosis and applied the name "essential thrombophilia" to these cases. They found an increased platelet count and increased coagulation time of the blood plasma and presumed that the thrombosis in their cases was explained on this basis. Such cases now would be expected to show an increased heparin tolerance test, as described by DeTakats. One of the cases reported in the paper probably belongs to this group. Acute arterial thrombosis may also result from trauma. In 1940, in a paper entitled, "Acute Traumatic Arterial Thrombosis of the Extremities", we reported three cases of arterial thrombosis occurring in previously healthy individuals. The first case was that of

a machinist who developed a brachial thrombosis presumably from using a water hammer; the second, a tractor driver who developed popliteal thrombosis, and the third a banker, who developed a thrombotic occlusion in a pre-existing popliteal aneurysm.

TREATMENT

Treatment of peripheral arterial embolism depends on the extremity involved, the site of the arterial occlusion, the duration of the occlusion before a diagnosis is made, and the general condition of the patient.



Medical management is indicated when the embolism is low or in a small artery or when the case is seen later than ten hours after embolism, and for embolism of the upper extremity, where collateral circulation is so abundant.

The medical treatment consists of opiates for pain, of antispasmodic therapy with papaverine hydrochloride and repeated injections of the sympathetics, of anticoagulant therapy with heparin and dicoumarin and of continuous use of the rhythmic constrictor. The new drug, tetra ethylammonium bromide will be useful. It will produce a sympathetic block when given intravenously or intramuscularly. The extremity should be level with the bed or slightly lowered. It should be wrapped loosely in cotton in order to preserve its natural warmth. Cooling reduces the metabolism of the part and thus lessens its need for blood, but it also increases the vascular spasm present. Therefore, unless it is known that irreversible changes have occurred and that amputation is inevitable, cooling should be withheld. Lumbar sympathetic novocaine injections should be done repeatedly if refrigeration is resorted to to offset the spastic effect of cooling. Anticoagulant and antispasmodic therapy are extremely important in preventing thrombosis of the artery distal to the site of the embolus.

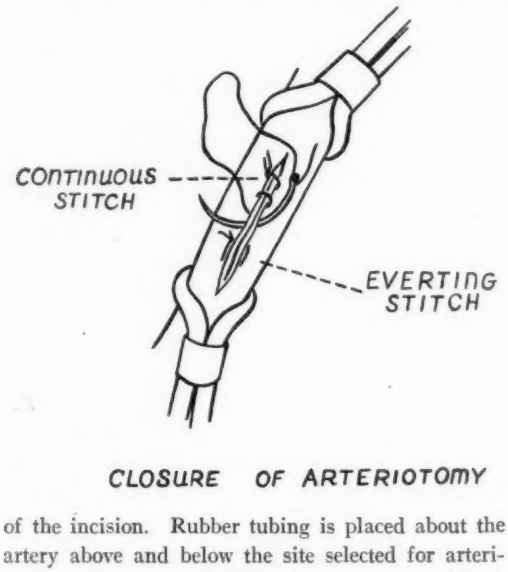
IMMEDIATE TREATMENT OF ARTERIAL OCCLUSION

1. Place extremity in dependent position (10 or 15 degrees below the horizontal).
2. Wrap extremity in sheet wadding.
3. Inject intravenously a potent vasodilator. (papaverine hydrochloride ½ gr.)
4. Begin anticoagulant therapy even if embolectomy is considered —heparin 50 to 75 mg. intravenously every three hours. Occlusion of the terminal arteries by a tail thrombus distal to the embolus may make an otherwise successful embolectomy a failure.
5. Relieve vasoconstrictor spasm by paravertebral novocaine block of the related sympathetics.
6. If there is evidence that the occlusion is in the femoral or iliac artery or at the aortic bifurcation, consider embolectomy as an emergency procedure to be done within six or eight hours from onset of the occlusion.

Surgical treatment is indicated in embolism to the bifurcation of the aorta, in embolism to the femoral, above, below or at the femoral bifurcation, and in embolism to the popliteal artery in exceptional instances. Aortic embolism is apt to be fatal without embolectomy. In Scandinavia, the home of embolectomy, physicians have learned to diagnose their cases early enough to permit use of frequent and successful embolectomy. Thus, Nystrom in 1936 was able to report 382 Swedish cases, with restored circulation in 22.5 per cent. Twenty-one (21) successful aortic embolectomies, reported in the literature, were reviewed by McClure and Harkins in 1943. And, as mentioned previously, Murray in

1943 was able to report 5 successful aortic embolectomies, in all 5 of which there were no technical difficulties and no accidents or disaster. It can be said that about one-half of patients having embolectomies within the first ten hours will leave the hospital with restored circulation.

As the majority of emboli occur in the femoral or iliac arteries, the usual site of embolectomy will be over the common femoral, with the abdomen left exposed for extension upward of the incision if necessary. The incision is preferably made below the largest part of the distended artery, so that the tail thrombus can be removed before the main embolus and the blood pressure may force the embolus out



CLOSURE OF ARTERIOTOMY

of the incision. Rubber tubing is placed about the artery above and below the site selected for arteriotomy and about major branches—to control bleeding and to prevent fragments of emboli from passing down into the periphery. Suction and ordinary instruments may be used to remove the tail thrombus and the embolus. When a free flow of blood is obtained from above, the incision in the artery is closed. One or two interrupted sutures are placed to evert the intima and the suture completed with continuous arterial silk. Anticoagulant therapy and sympathetic nerve blocks should proceed and follow embolectomy. Heparin therapy should be started as soon as the diagnosis of arterial embolism has been made. This is done to prevent a thrombus from occurring within the arterial system distal to the embolus, until the removal of the embolus can be carried out. After the peripheral thrombus and embolus have been removed, 2 or 3 cc. of heparin are injected intra-arterially at the site of the arteriotomy. In the lower extremity, peripheral embolectomy performed under local anesthesia and supplemented by lumbar sympathetic nerve block, papaverine and heparin and performed within 6 hours of the onset of the occlusion offers an excellent prognosis.

I have had no experience with the technique of aortic embolectomy. Murray writes that the technical procedure of removal of such an aortic embolus is not difficult, and if undertaken within 12 to 20 hours after the accident and successfully completed, changes the prognosis to one of optimism providing the pre-existing cardiovascular disease has not itself jeopardized the chances of the patient.

Murray uses an abdominal extra-peritoneal approach. The incision is a right paramedian one, extending from 2 inches above the umbilicus to the symphysis. The transversalis fascia is divided and the peritoneum is bluntly dissected out of the right iliac fossa and retracted. Bull-dog clamps are applied around the right and left external and internal iliac vessels. A surgical tape is passed around the aorta in the form of a loop above the embolus. The arteriotomy is made through the most accessible spot of the right common iliac. A profuse squirt of blood proves that the circulation is cleaned of clots. The bull-dog clamps are tightened above and below the incision in the artery, 500 units of heparin in saline are placed in the lumen of the vessel through the open incision and the incision closed with a continuous silk stitch, placing the stitches not more than 1/16 inches apart. About 800 more units of heparin are injected through the wall of the right common iliac before closing the abdominal wound.

Linton has described a somewhat similar aortic embolectomy, using Bethune lobectomy tourniquets to temporarily occlude the arteriotomy site. He simplifies the procedure by isolating the iliacs only and performing arteriotomy through the right common iliac without a tape about the aorta.

SUMMARY

Arterial embolism of the extremities is a surgical emergency. Restoration of the circulation by embolectomy is the treatment of choice for aortic and lower extremity occlusions. To offer a good prog-

nosis, aortic embolectomy should be undertaken within 12 to 20 hours from the onset of the occlusion; femoral embolectomy, within 6 hours. Medical management is the treatment of choice for embolism of the upper extremities, for cases seen late, and for embolism of smaller arteries. Anticoagulant therapy and sympathetic nerve block are important adjuvants of both the surgical and medical treatment.

CASE REPORTS

THROMBOSIS OF THE POPLITEAL ARTERY

Case 1.—Mr. R. F., age 56, a printer by trade. Admitted to De Paul Hospital on 12/25/45. A patient of Dr. Richard Reynolds.

History: The day before admission to the hospital the patient had awakened with a cramp-like pain in the right foot. He went to work but was forced to return home after several hours because of severe pain in the calf of the same leg and marked coldness of his foot. The patient's previous health had been good. He had observed no prior leg pain or coldness and had no claudication on walking.

Examinations: B. P. 140/90, Temp. 98.6, pulse 100. General physical examination normal other than the right lower extremity. There was no cardiac arrhythmia and no murmurs. The right foot was blanched, cadaveric and cold. There was a change from low to warm skin temperature at about the junction of the middle and lower third of the leg. Local tenderness was marked in the calf. No pulsation was detectable in the right dorsalis pedis, popliteal or femoral artery. Although femoral pulsation was not observed by palpation, an oscillometric index of ½ point was obtained in the right midthigh. No abnormal findings were noted in the opposite extremity.

Treatment and Clinical Course: The right lower leg was bandaged with several layers of sheet wadding, the head of the bed was elevated, whiskey was given by mouth and spasmalgin by "hypo". The lumbar sympathetics were injected with novocaine every 12 hours for 3 times, the rhythmic constrictor was used for 2 hour sessions three times daily. Dry gangrene gradually developed and eight days after admission there was a definite line of demarcation several inches below the knee. A good pulsation was now detectable in the femoral artery and an oscillometric index of ¾ths point was present just above the right knee. A histamine test gave positive reactions in the thigh and a fair wheal just below the knee. The leg was packed in ice up to the line of demarcation. Eleven days after admission, a Callender type of lower thigh amputation was performed under spinal anesthesia. There was a normal post-operative course with primary healing of the stump. The patient was discharged on 1/15/46, twenty-one days after the onset of his illness.

Comment: Arterial spasm accounted for the signs of diminished femoral circulation, an interpretation subsequently substantiated by an increased oscillometric index and a good femoral pulsation on the eighth day after admission. The medical treatment of occlusive arterial disease instead of arteriotomy was initially elected because of the following points: The occlusion was in the popliteal artery, the occlusion was due to thrombosis rather than embolism, the case was first seen 24 hours after the onset of his illness.

Case 2.—Mrs. T. H., age 42, a patient of Dr. Bryan Grinnan and Dr. Albert Crosby. Admitted to De Paul Hospital 1/5/45.

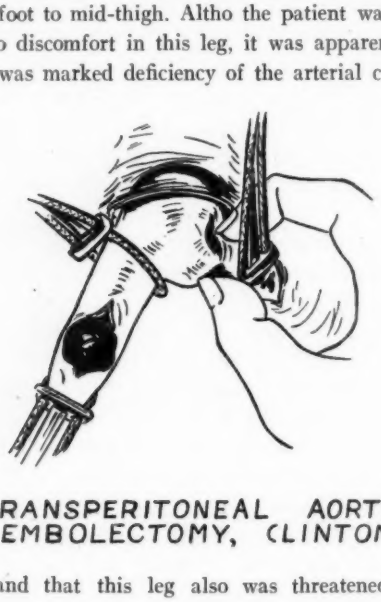
History: The patient complained of shortness of breath and vomiting. She had had two previous admissions for cardiac insufficiency. She was seen the evening of admission by Dr. Grinnan, who made a diagnosis of rheumatic heart disease with mitral stenosis, mitral insufficiency with auricular fibrillation, and signs of fluid at right base. The next morning the cardiac symptoms and signs were better but the patient was complaining of severe pain and numbness in the right foot and lower leg. The right foot was colder and paler than the left. Dr. Grinnan made a diagnosis of embolus to the right popliteal artery.

Clinical Course: The patient's cardiac status remained precarious. She complained only slightly about her right leg, altho the foot remained cold and the skin very pale. On the fourth day after admission, the patient had sudden pain in left chest, increased by breathing, and a diagnosis of pulmonary embolus was made. Two days later, severe pain again developed in the right leg and the leg from the knee down was observed to be cold and cadaveric. A second embolic episode to the right leg was presumed.

I first saw the patient on 1/16/45, eleven days after admission, at the request of Drs. Grinnan and

Crosby. A dry gangrene of the right leg was present. The toes were mummified. The skin from the knee down was pale and discolored. The dermatherm indicated that the level at which the surface temperature changed was in the lower third of the thigh. No pulsation was detectable in the dorsalis pedis, posterior tibial, popliteal, or femoral artery. Oscillometric readings were zero from foot to groin. Arterial obstruction with occlusion as high as the femoral was apparent.

The opposite (left) leg looked pale, and the veins were poorly filled. Oscillometric readings were zero from foot to mid-thigh. Altho the patient was having no discomfort in this leg, it was apparent that there was marked deficiency of the arterial circulation and that this leg also was threatened with gangrene.



TRANSPERITONEAL AORTIC EMBOLECTOMY, (LINTON)

We recommended packing the right leg, already gangrenous, with ice. Refrigeration would allow time to improve the patient's cardiac condition. Active therapy was begun to limit the extent of gangrene that seemed inevitable in the left leg. The leg was wrapped with sheet wadding and slightly cooled with two ice bags. Anticoagulant therapy was instituted, the rhythmic constrictor was used several hours daily.

On January 28th, twenty-three days after the patient's admission, Dr. Grinnan felt that the time was optimal for surgery and a guillotine type of lower thigh amputation was performed by Dr. Crosby under ethylene-oxygen anesthesia. Cardiac fibrillation developed during the procedure, but the amputation was completed in 12 minutes and the patient left the table in relatively good condition.

In the convalescent period, continued use of the rhythmic constrictor was made in the hopes of limiting the surgery on the left leg to a lower leg amputation. On 2/9/45 with the left foot now gangrenous, a histamine test gave positive wheal reactions several inches below the knee and on 2/12/45 Dr. Crosby performed a leg amputation about six inches below the knee. Ethylene-oxygen anesthesia was again used. The heart again fibrillated, blood pressure became unobtainable and a pulse was not palpable. Anesthesia was discontinued and oxygen given, and the patient again responded nicely.

The patient was discharged on 5/16/45, with a well compensated heart, a healed thigh amputation on the right, and a healed lower leg amputation on the left.

Comment: The patient was brought out of a serious episode of cardiac fibrillation and failure by an internist, a surgeon skilfully performed the successful amputations, a keen anesthetist overcame the hazards of the anesthesia. Handling of the peripheral vascular problems along modern lines enabled delaying surgery until the cardiac status could be improved and probably contributed towards a lower leg rather than a thigh amputation on the left leg. In retrospect one must conclude that the extremity pathology resulted from bilateral femoral embolism. A saddle embolus at the aortic bifurcation may have been present, fragmenting and descending first into the right and a few days later into the left limb. The leg symptoms came on insidiously while the patient's cardiac status was such as to cause grave fear of her immediate death, so that there never was opportunity for embolectomy.

EMBOLUS WITH TAIL THROMBUS

Case 3.—Mr. J. W., age 65, a patient of Drs. Salley, Gwathmey and Newcomb. Admitted to Norfolk General Hospital on 2/21/46.

History: A burning pain developed rather gradually in both legs the day before admission. Later in day, he developed severe pain in the right leg and both legs felt cold.

Examination: Right foot and lower leg cold, pale, numb, veins collapsed. A purplish mottling about right knee and thigh. Tenderness and pain in right knee and thigh over Hunter's canal. Left foot and lower leg numb and cold, but not pallid or ischemic. No dorsalis pedis, popliteal or posterior tibial pulsation in right inguinal region, slight femoral pulsation in right inguinal region; slight femoral pulsation at left inguinal level. Oscillometric readings were zero to well above knee on both sides. Skin temperature line of change from cool to warm at the junction of the upper and middle third of the right thigh, and at the junction of the lower and middle third of the left thigh. Heart sounds were recorded as distant but otherwise normal. The pulse was 80 and the B.P. 130/80. There was no evidence of fibrillation, cardiac decompensation or coronary infarction to account for the origin of the embolus, but the patient looked toxic, shocked, and was in a lot of pain. I made a diagnosis of rider or saddle embolus at the aortic bifurcation and, as the occlusion had now been going on for 24 hours, advised packing both legs in ice from foot to thigh. Nine mgms. of pantocaine were given intraspinally in the patient's room with marked relief of pain. Papaverine hydrochloride was given intravenously and whiskey by mouth was given for several days.

Subsequent Course: Dry gangrene of both lower legs developed, but the patient's general condition improved and he was free of pain with his lower extremities constantly refrigerated. Guillotine amputation of the right leg through the upper thigh was performed by Dr. Gwathmey on 3/16/46 under refrigeration anesthesia.

A similar procedure was performed through the upper third of the left thigh on 3/22/46. The patient's subsequent course was one of continued improvement. Both stumps healed well. The patient is well and actively conducts a large business at this writing.

Comment: The embolus probably arose from an atheromatous plaque in the aorta, and lodged temporarily at the aortic bifurcation and then descended as two fragments, one into each femoral. The occlusion was evidently at the femoral bifurcation on both sides, for a pulse could be felt at the left inguinal ligament level.

In retrospect, a bilateral femoral embolectomy under local anesthesia certainly could have been tried when the patient was first seen, but the patient had refused hospitalization during the first twelve hours of his illness. Heparin therapy the night of admission might also have been beneficial. Refrigeration of both extremities for a period of 3 weeks was most valuable, permitting amputation after the patient's general condition was much improved. Patients with such massive bilateral gangrene usually die of toxemia, rarely recovering enough for amputation.

Case 4.—Mrs. H. C., age 42, was under the care of Dr. M. S. Fitchett because of mitral stenosis and auricular fibrillation. Two months prior to her admission to the hospital she had had increased shortness of breath and observed that there was pain in the left foot and calf on walking. A week prior to admission she had an episode of sudden pain in the right thigh along Hunter's canal and over the knee, lasting for several hours. Spontaneous pain disappeared, but the right leg also became cold and the patient now experienced claudication in both legs on walking a few feet.

The patient entered De Paul hospital on May 5, 1945, a week after her last episode of spontaneous pain. Dr. Fitchett's note recorded an enlarged heart with a presystolic mitral murmur. The cardiac rhythm was totally irregular. B. P. 110/70. I saw the patient on 5/9/45. She did not appear ill. There was definite coldness of both lower legs. There was blanching on elevation and slow filling of the veins on dependency. Repeated flexion of the ankles with the legs elevated reproduced the patient's claudication pain. No pulsation was noted in the dorsalis pedis, posterior tibial, popliteal arteries of either leg. Femoral pulsation was variable, at times being present, at times absent. Oscillometric readings were good above the knee on both sides and zero below. A diagnosis of bilateral popliteal occlusion from small cardiac emboli was made. Buerger's exercises were prescribed and the patient was given rhythmic constrictor apparatus to use on each leg for six hours daily at home. Her leg symptoms progressively improved. The feet became relatively warm and the patient could walk several blocks without claudication.

Comment: The mural cardiac emboli in this case

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were probably small and friable, resulting in small emboli to the periphery at widely separated intervals. This interpretation is substantiated by the subsequent course of events. Several months after the above described leg complications, the patient suddenly developed dizziness, headache and weakness of one side of the body. She gradually recovered from the episode—probably a small cerebral embolus. The spastic element must have been marked because for a time no pulsation could be detected in the femoral arteries, yet complete recovery of peripheral arterial circulation ensued.

Case 5.— Mrs. M. C., Age 23, 2½ weeks post-partum and ambulatory, suddenly noticed about 5 A. M. of 8/13/46 that her right foot was cold and numb. She was not unduly alarmed and did not call her doctor — Dr. Altizer — until pain developed in the lower leg and back of knee. This was about 5 P. M. Dr. Altizer saw patient shortly thereafter and immediately made a diagnosis of occlusive arterial disease of the right leg. The patient was admitted to De Paul Hospital at 6:30 P. M., and was seen by Dr. Altizer and myself at once. There was definite diminished temperature of the right leg from toes to just above the knee. No pulsation was detectable in the dorsalis pedis, posterior tibial, popliteal or femoral artery. Just above the inguinal ligament the iliac pulsation was forceful and full. The foot and lower leg were pallid, the veins collapsed. Our impression was that the patient had arterial occlusive disease probably at the femoral bifurcation. Altho it was now thirteen hours since the onset of the present illness immediate femoral exploration was decided on. Five c.c. (500 units) of heparin were given intravenously as the operation was begun. Pantocaine-glucose spinal anesthesia was used. The incision began just above the crease in the groin, in line with the pulsating iliac artery, and extending downward several inches. On exposing the femoral artery, it was found to be non-pulsating, firm and obviously swollen by a thrombus. Arteriotomy was performed in the common femoral. A red thrombus immediately extruded itself from the incision in the artery. Suction applied distally resulted in the extraction of a red organized "tail thrombus" about 20 cm. long and 3 mm. in diameter. This was followed by a retrograde flow of blood. A gallstone forcep was then used to apply traction to the thrombus protruding from the upper end of the arteriotomy incision and a thrombus several cm. in length came out, followed by a violent gush of blood. Traction was made on the rubber tubings previously placed to control bleeding, five cc. of heparin were injected into the arterial lumen and the arteriotomy incision closed with closely placed fine arterial silk. No difficulty was experienced in getting good closure of the arteriotomy. Post-operative orders were as follows: Papaverine hydrochloride gr. ¼ intravenously every 4 hours, 300 mgms. of dicoumarin stat., continuous intravenous drip containing 2 ampules (20,000 units) heparin to the liter, inhalations of 100% oxygen with the B.L.B. apparatus, novocaine block of the right lumbar sympathetics every 12 hours for 2 days.

In the next few days, in spite of a definitely pulsating femoral artery and a warm thigh and upper leg, the foot became gradually colorless and cold. Dry gangrene seemed inevitable, so ice bags were applied to control pain and a line of demarcation awaited. A lower leg amputation was performed on 10-4-46, a guillotine type of amputation, as the first incision unexpectedly passed through infection in the fascial spaces, and a second incision higher up had to be made. Convalescence from the leg amputation was uneventful until 10-28-46 when pain and tenderness developed in the left iliac region. Left ilio-femoral thrombophlebitis was suspected. Several days later these symptoms disappeared and a split thickness graft was applied to the stump. This took 100% and the patient is now ambulatory, using crutches.

Comment: This is probably a case of idiopathic simple arterial thrombosis or "essential thrombophilia." Nygaard and Brown reported five cases so classified in 1933. As the cause is thought to be an increased coagulability of the blood, arteriotomy and thrombectomy was indicated in an age of potent anticoagulant therapy. As the common femoral was completely occluded a thigh amputation seemed inevitable. Had it been possible to perform the arteriotomy earlier—say within 6 hours— and before the lower arterial radicals had become thrombosed, an even more favorable outcome would have resulted.

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Deer Hunters Warned.

Now that the hunting season is on, Clay Schoenfeld warns in the current issue of *Hygeia*, health magazine of the American Medical Association, take it easy when you go deer hunting. You're just about as likely to die of a heart attack as of a stray bullet.

Almost 40 per cent of the deer-hunting deaths in the United States are due to heart attacks, according to the writer, a Madison, Wisconsin resident who speaks from personal experience in the north woods as well as from data compiled by various state conservation departments. Out of 18 hunter deaths in the state of Michigan during the 1946 deer season, he says, "10 were due to gunshot and eight to heart disease. In Wisconsin the heart cases actually outnumbered the bullet toll eight to five."

The trouble is that "the average man in the woods operates unconsciously at a pace and under a strain which he wouldn't think of putting up with back home," Mr. Schoenfeld observes. "The fellow who can't walk a block to catch the bus suddenly goes tramping through underbrush on a 10-mile deer drive. The man who never carries out his furnace ashes decides to drag a 200 pound buck a half-mile back to the road. Or the chap who sits calmly for 51 weeks at a desk stands by the hour with pounding pulse at a deer crossing. . . .Most of the 1946 heart attack victims were hunters in the middle age group, men no longer in their physical prime who got too excited or strained themselves in the woods. . . .Weak hearts aren't limited to men past 40, however. Several diseases of childhood lead to heart weaknesses among younger people. Rheumatic fever is the worst offender."

New Books.

Among the recent books received at the Library of the Medical College of Virginia are the following, which are available to our readers under usual library regulations:

Beck—Obstetrical practice. 4th ed.
Behrend—Diseases of the gall-bladder and allied structures.
Bierman—Physical medicine in general practice.
Conel—The postnatal development of the human cerebral cortex. Vol. III.
Edgerton—Readjustment or revolution?
Galen—On the natural faculties.
Gardner—Katherine Kent.
Grant—An atlas of anatomy. 2nd ed.
Hinselwood—The chemical kinetics of the bacterial cell.
Holmes—Introduction to clinical neurology.
Holmes and Robins—Roentgen interpretation. 7th ed.
Karsner and Koletsky—Calcific disease of the aortic valve.
Kraetzer—Procedure in examination of the lungs.
de Laubenfel—Life science.
Leonardo—History of medical thought.
Lewis—Diseases of the heart. 4th ed.
McComb—Internal medicine in general practice. 2nd ed.
Rosenberg—Chemistry and physiology of the vitamin.
Rubin—Diseases of the chest.
Strecker—Fundamentals of psychiatry.
Strecker and Ebaugh—Practical clinical psychiatry. 6th ed.
Strain—Teen days.
Waksman—Microbial antagonisms and antibiotic substances.
Wechsler—Clinical neurology. 6th ed.
Wiener—Skin manifestations of internal disorders.

XUM

THE TREATMENT OF SEVERE COMPOUND FRACTURES OF THE FOOT

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The orthopedic section of a general hospital while overseas treated 486 compound, comminuted, fractures of the foot, excluding phalanges, during the year of 1944. Although not all of these injuries could be classified as severe, the majority were the results of high explosive shell fragments or small arms fire. Many of the more severe wounds of the feet ended in amputation before reaching our hospital, and 8 that reached us had to be amputated, necessitated by severe tissue loss, infection or circulatory failure. There were many, however, that required radical treatment to achieve a useful foot.

An analysis of these fractures is shown by the table below.

Compound, comminuted fractures	Number Cases	Battle Casualties	Non-Battle* Casualties	Assoc.† Injuries	Numbers &‡ Type of Duty	Average Days Hosp.
Metatarsal	234	164	70	88	43—A	72
					36—B	74
					155—C	44
Tarsals	150	114	36	94	24—A	74
					19—B	90
					107—C	48
Os Calcis	102	80	22	47	7—A	64
					9—B	82
					86—C	44
Totals	486	358	128	229	74—A	70
					64—B	83
					348—C	45.3

*More than 90% non-battle casualties were caused by soldiers own rifle at close range.
†Included in associated injuries are such things as fractures of long bones, head, chest and abdominal wounds.
‡A represents full duty; B limited assignment; C Zone of Interior for more time or treatment.

Early experiences with severe compound, comminuted, fractures of the foot were not yielding satisfactory results. Patients with many small fragments developed sepsis, particularly if the short bones were involved. Nearly always in fractures of the tarsal bones a joint is involved and infection destroys the articular cartilage. The result is a partly fused, draining, painful joint. Before operation many of these cases were septic with temperatures ranging up to 102 degrees. These required further excision of dead tissue, with every effort being made to obliterate all infected or potentially infected joints and dead space.

It was found that when soft tissue defects were allowed to granulate, healing appeared to progress slowly for 60 to 90 days, but not to completion. Frequently the wound would break down and drain profusely. This was particularly true if the wound had been made by a shell fragment, with increased soft tissue damage resulting in an excess scarring with contractures, and poorly healed skin or often keloid formation. Hence it was decided to make every effort to close the soft tissue, even if removal of some normal bone was necessary.

Reparative surgery optimum time is between 5 to 10 days provided the general condition of the patient permits. Unfortunately, many of these cases for various reasons were not admitted to this hospital until 15 to 25 days after injury. All received systemic penicillin therapy and blood replacement therapy prior to surgery.

After closing the deep layers as completely as possible, the skin on the plantar surface was sutured, utilizing relaxing incisions if necessary. If possible, the skin on the dorsum of the foot was also closed at this operation—depending on the wound condition. Usually the wound on the dorsum could not be closed and required grafting later. These grafts were placed as soon as possible, without permitting the wound to granulate to the level of the surrounding skin, in an effort to avoid later pressure on the resulting scar.

Written by author while in Service as Major in the Medical Corps.

CASE REPORTS

Case 1.—Age 28. This soldier was wounded in action by shell fragments on 8 April 1944 at Anzio, Italy, receiving the following wounds of the left foot: fracture, compound, comminuted, complete, 4th and 5th metatarsals with loss of 90 per cent of bone substance of these 2 bones; fracture, compound, comminuted, complete, 3rd metatarsal, cuboid and 2nd and 3rd cuneiforms; and a severe perforating wound of foot over the area of 3rd and 4th metatarsals from dorsal to plantar surface, both entrance and exit measuring 10 x 8 cm., following the debridement. He was received four days after injury and penicillin therapy instituted six days after injury. At operation, all devitalized bone was removed, which included the remaining parts of the 3rd and 4th metatarsals, and both wounds were sutured. The wounds healed per primam. He began to walk with crutches about 6 weeks later. He was discharged to limited duty 83 days after injury, 77 days after operation, with only a slight limp and a foot that had two painless concave scars.

Figure I (Case 3).—Showing dorsum of foot with skin grafted area.

Case 2.—Age 24. This soldier was admitted to the base hospital 22 days after injury. He had sustained a wound of right foot when he fell and accidentally discharged his own M-1 rifle. The injuries as seen on admission were a compound, comminuted, fracture of 2nd and 3rd metatarsals with about 50 per cent loss of bone substance, and a perforating wound of middle of the foot, 10 x 8 cm. on the dorsum, and a previously sutured and healed 10 cm. exit on the plantar surface. On 24 January 1945, 25 days after injury, a further debridement was done and because 50 per cent of the 2nd metatarsal and both tendons to the 2nd toe were found destroyed, the phalange and nail were removed and the skin used as a pedicle graft to partly close the wound of entrance on the dorsum of the foot. About three weeks later, the remainder of the defect was closed with a split skin graft measuring 6 x 3 cm. with a resulting 100 per cent take. Ten days later, a walking cast was applied and protected weight bearing instituted. Six weeks after operation, the cast was removed and weight bearing begun, aided by a specially made stainless steel arch support and crutches. Two weeks later, he was walking with only a moderate limp without crutch or cane. At

Figure 2 (Case 3).—Plantar wound which was secondarily closed.

the end of 12 weeks, the soldier returned to limited duty.

Case 3.—Soldier, age 24, was wounded in action on 2 December 1944. He was received at the base hospital 10 days later with a notation on the chart that an amputation would be needed in the general hospital. Four days later, after penicillin and blood therapy had been initiated, examination in the operating room revealed a compound, comminuted, fracture of the 3rd metatarsal, first cuneiform and cuboid, with a complete avulsion of 2nd metatarsal and 2nd and 3rd cuneiforms. The circulation of the foot appeared good and there was only moderate infection. After all loose fragments and devitalized tissue including the 1st cuneiform and cuboid, were removed, it was possible to close a 6 x 4 cm. wound

Figure 3 (Case 3).—X-rays showing loss of cuboid and all cuneiform bones, all of metatarsal 2nd, and 50% of metatarsal 3rd, with partial fusion at scaphoid and first metatarsal junction.

on the plantar surface of the foot. The 1st metatarsal required fusion to the scaphoid in order to obliterate the dead space. Six days later, the wound was dressed and some additional debridement was found necessary. Seventeen days later, a 10 x 6 cm., split skin graft was placed on the wound on the dorsum of the foot. Eight weeks after the operations, the wounds were completely healed. A walking iron was applied to the cast and he was allowed to walk without crutches. On 23 February 1945, about 10 weeks after operation, his cast was removed and with a specially made arch support in his shoe he began to bear weight on this foot. X-rays at time showed partial fusion. He was walking without discomfort. Three months after operation all wounds remain healed, he is walking with a moderate limp, with no support except the one in his shoe.

Case 4.—This Brazilian soldier was wounded in action by shell fragments on 12 December 1944. Penicillin therapy was initiated and his blood levels brought up to normal by transfusions. On 3 January 1945, soon after admission to our hospital, the following conditions of left foot were found. There was a severe penetrating wound, 10 x 5 cm. on posterior medial aspect of heel, lacerating ⅔ of the tendon achilles and a wound 6 x 2 cm. on posterior lateral aspect previously made for removal of foreign bodies. These wounds were pocketing large amounts of pus. There were also compound, comminuted, fractures of os calcis, and astragalus with loss of ⅓ of the bone substance of the superior aspect of os calcis. At operation the wound on the plantar aspect was enlarged and a complete debridement done. Since the inferior articular cartilage of the astragalus was exposed and comminuted, and since the superior articular surface of os calcis was destroyed, an arthrodesis was carried out as a precaution against sepsis. The wound was not sutured and a long leg cast was applied with the knee flexed 80 degrees. Seven days later the wound was dressed, found to be clean and the plantar wound was sutured. The soft tissue defect was too great to effect a closure, so it was permitted to heal by granulation. Ten weeks later, the wound was completely healed and x-rays showed beginning fusion between the astragalus and the os calcis. Three and one-half months after operation, he was bearing weight with the aid of crutches. Since this fracture of the astragalus was so severe and also extended into the ankle joint, he may require a fusion of the ankle, but a serviceable foot should eventually be obtained.

SUMMARY

Four cases are presented representing the severe injuries of the foot as observed in a base hospital. The results were not as good in all similar cases. However, the results obtained by this method of

management far surpass those achieved by the previously employed conservative measures.

The recommended procedure is as follows: As soon as it is feasible, usually 5 to 10 days post-wounding, with the patient receiving penicillin therapy, and having received adequate blood replacement, at operation all dead and potentially dead tissue is removed, all infected or potentially infected joints are excised and the dead space obliterated. The plantar wound is closed at first operation of reparative surgery if possible. The dorsal wound is left open for drainage if necessary but sutured later if possible. When skin grafting is necessary it is done early and on a depressed rather than elevated area. During treatment the foot is immobilized in plaster of Paris boot.

The advantages that this procedure has over the conservative or closed plaster method are: sepsis is prevented or its chances minimized, thus saving some feet that were previously amputated, and chronic draining sinuses from painful joints are not obtained. Wounds heal much more rapidly keeping scarring to a minimum, which allows early motion and weight bearing and prevents ankylosis of uninvolved joints.

Professional Building.

Floral Eponym (57)

SARRACENIA

SARRAZIN, MICHAEL S., 1659-1736

There seems to be some doubt as to which Dr. Sarrazin Sarracenia is named. Bailey says that Dr. D. Sarrasin of Quebec, a well known physician and naturalist who sent S. purpura to Tournefort nearly two centuries ago, is the man. On the other hand Kelley (Some American Medical Botanists, Troy, N. Y. 1914) quotes from J. B. Tournefort as follows: "Sarracenam appelavi a Clarissimo D. Sarrazin, Medicinae Doctore, Anatomico et Botanico Regio insigni, qui eximiam hanc plantam pro summa qua me complectitur bene volentia e Canada missit." Kelley says further "No initials are given to this Sarrazin and many have assumed that a Dr. Jean Antoine Sarrazin is meant. But Jean Antoine was born in Lyons, France, April 25, 1547 and died there November 29, 1598. As he went out of the world ten years before Tournefort came into it, he manifestly did not send the flower to Tournefort. Michael S. Sarrizin undoubtedly the real sponsor, was born in 1659." He came to Canada in 1685, and several years later was appointed King's physician for the country, the only bearer of that title in all of New France. He also had the honor of being elected to the French Academy.

Sarracinia is a genus of American bog plants. The common name is pitcher plant. They have pitcher-shaped or tubular leaves. The S. purpura, or huntsman's cup, has been vaunted as a cure for smallpox. S. flava, S. drummondii and S. variolaris are Southern species.

XUM

COOPERATION BETWEEN OCULISTS AND GENERAL PRACTITIONERS

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The family physician or the pediatrician usually sees the cross-eyed or squinting child before he is referred to an eye man. Too often the advice given is to wait and see if the child doesn't outgrow it in a year or two and, if not, then see an eye specialist. This is especially likely to happen if the squint is only slight. About 25 years ago a mother was given such advice but was not satisfied, so she brought her two year old child in. One glance with the ophthalmoscope revealed a tumor that filled about ½ of the vitreous chamber. The eye was removed the same day and the nerve cut as far back in the orbit as possible. The tumor was malignant but had not metastasized, as evidenced by the fact that she is well today and has two children of her own. I do not mean to suggest that every case of early squint should necessarily be treated in infancy. If the case is one merely of imbalance of ocular muscles there is no reason why we should not temporize, as many of these cases, in fact most of them, outgrow it. But I do want to emphasize the fact that any eye that is blind or that has very poor vision is apt to show some degree of squint, and the squint may be the first sign of a malignant or progressive disease calling for immediate treatment. Another point to bear in mind is that the amount of squint is of little or no importance, as it depends almost wholly on the amount of muscle imbalance. The all-important thing is the presence of some squint, which almost always means that the squinting eye is not being used. If examination shows nothing organically wrong, it is safe to put things off, but every child with any degree of squint deserves an examination rather than a guess.

I have had a number of children referred to me by the family physician for crossed eyes, when it was easy to show that the eyes really were straight. The bridge of the child's nose is usually flat, and if the skin is a little redundant, a fold develops, crescentic in shape, which hides the inner canthus and part of the sclera to the nasal side of the cornea. This is called epicanthus, and gives the appearance of a low degree of internal strabismus. The simplest way to determine that the eyes are straight is for the observer to hold near his own eye a flash-light directed toward the child's eyes. When the child looks at the light, the observer will see a tiny, bright reflection from the child's corneae which will appear to be near the center of the pupils if the eyes are straight. If there is a squint, the reflection from the fixing eye will be in the center of the pupil and the reflection from the squinting eye will occupy some other position. This is easily demonstrated to the parents and will usually satisfy them. As these children grow older the bridge of the nose elevates, gradually drawing the redundant skin away from the inner canthi, allowing the eyes to appear straight. In very excessive cases plastic surgery must be resorted to for cosmetic reasons.

There is another group of children who usually see the ophthalmologist first, but whose treatment should be conducted by the family physician. They are of the scrofulous diathesis, under-nourished, with prominent glands in the neck, whose parents call them "puny" and do nothing about it. When, however, the eyes get red, run water, and are kept closed all the time, they are brought to the eye clinic. These are cases of phlyctenular disease. There have been many theories as to the cause, one of the most attractive being that the patient has become sensitive to some allergen, usually tuberculous toxin, and when some of the allergen gets into the eye, phlyctenules develop. They have been produced experimentally in that fashion. The phlyctenules are little raised, yellowish nodules in the epithelium about the size of a pin-head or smaller, surrounded by a red zone, usually multiple, showing a predilection for the limbus. Regardless of the cause, we know that we can make them melt away in short order by dusting a little powdered calomel in the eyes once a day, but this treatment does not prevent rapid recurrences. The real treatment used to consist in cod-liver-oil, balanced but abundant diet which limited candy and pastries severely, fresh air and sunshine. I doubt if more modern methods are any more effective.

Another condition that we not infrequently encounter is intraocular tuberculosis. Strangely enough this is usually found in apparently robust individu-

als in good health and is almost never seen in people with pulmonary tuberculosis or in inmates of t.b. sanitaria unless the tuberculosis is of the miliary type. It is usually seen as a chorio-retinitis, and in early cases the area involved is smaller than the optic disk or nerve-head. The diagnosis can be made by the ophthalmoscopic appearance, high sensitivity to the intradermal or patch tuberculin test, focal reaction to tuberculin, and its chronicity. It is quite refractory to simple foreign protein injections but soon begins to resolve under properly graded tuberculin therapy. I am fully aware that practically all modern internists scoff at tuberculin as a therapeutic agent. I am equally aware that many, if not a large majority of our most astute ophthalmic clinicians consider tuberculin as our sheet anchor in such cases. Why does it work in ocular tuberculosis and not in tuberculosis located elsewhere? I have never heard a thoroughly satisfactory answer, but in thinking it over an idea occurred to me which you may take for what it is worth. In the eye the lesion is open to clear inspection, whereas in the lungs or peritoneum it is covered with integument and many centimeters of tissue. In the eye a very small lesion will render the affected portion of the retina blind, thus bringing the condition to notice almost at its inception in contrast with the delay usual when it attacks other organs. With the ophthalmoscope we get an effective magnification of 14 diameters, so that the average lesion seen early will really be a flat disk about one millimeter in diameter and about as thick as a piece of paper. A chest lesion that the internist would consider early would be about the size of a black-eyed pea, the volume of which would be a thousand times that of the early ocular lesion. The infinitesimal amount of tubercular toxin liberated by the tiny ocular lesion is inadequate to stimulate the general body defense against the infection, so the administration of the toxins by "hypo" in proper dosage is used to stimulate the defense mechanism. Even a slight over-dose has a very deleterious effect on the lesion, but we can watch the lesion in the eye constantly and reduce the dose drastically at the first unfavorable sign. In the case of the chest lesion, which is probably several thousand times greater in volume, there is doubtless more tuberculous toxin liberated into the blood-stream than is needed to stimulate general defense, and the patient is having at all times a result that is comparable to the results we get in ocular tuberculosis when too much tuberculin is injected. Obviously in such a case the administration of tuberculin would be adding insult to injury. Furthermore, if all of the above is in error and if tuberculin in guarded dosage would be beneficial in pulmonary tuberculosis, the fact still remains that the internist cannot watch his lesion with sufficient accuracy to detect the first signs of an over-dose, and probably his first indication would be a general reaction to the tuberculin, which never comes until after considerable damage has been done by the tuberculin injected. So, for my part, I am willing to have the internists abandon tuberculin for therapy, and to have the oculists continue to save eyes by its use, and I believe each is right in his own field. My chief point is that in a case of ocular tuberculosis, the internist should not take over the administration of tuberculin but should insist that the oculist do it so that the lesion can be diligently observed throughout the whole course of treatment, which usually takes several months for primary desensitization, and periodic booster doses for an indefinite time, probably for life.

One of the dreaded fundus pictures that we see shows white or yellowish spots, small flame-shaped or round hemorrhages and retinal edema. The most frequent causes are vascular disease, renal disease and diabetes. A great deal of work has been done in an effort to classify the degree of retinal involvement in cases of hypertension, but I believe the results are rather fine-spun and are of more theoretical interest than practical value. I have seen as many as three grades of involvement shown in different vessels of the same retina, and not infrequently there is a marked difference in the vessels of the two eyes, so we have to guess which picture gives the truer index of the condition prevailing in the vascular tree generally. Certain features of the retinopathy described may be more prevalent in nephritis, and others may be more often found where diabetes is the cause. A case of diabetic retinopathy in a mildly arteriosclerotic individual may present a picture indistinguishable from albuminuric retinitis; also, some cases of malignant hypertension may go to an advanced stage before there is much retinal evidence of disease. Certainly the internist can diagnose diabetes, nephritis and hypertension with greater ease than the ophthalmologist, his prognosis will be more accurate, and the management of the

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condition is his in the first place. I don't mean to minimize the importance of retinal examinations, but I do believe that their chief value is in the fact that often the first complaint concerns the eyes, and the retinal picture gives us the first clue that something is seriously wrong. Exhaustive study of the fundus to arrive at a differential diagnosis is largely a waste of time, when the desired information may be so easily obtained by a blood and urine examination.

Retro-bulbar neuritis has been described as a disease having one symptom and no signs, the patient seeing little and the doctor seeing less. The peripheral fields of vision may be normal, but there is a central scotoma so that the patient sees everything except what he tries to look at. Nothing can be found wrong in the eye by objective examination. Usually there is a marked improvement, and frequently complete recovery in a few weeks. My reason for bringing this disease to your attention is that it is caused by multiple sclerosis in about 75 per cent of the cases, often antedating any other symptom by as much as ten years. In a series of over five hundred proven cases of multiple sclerosis, about 50 per cent of them gave this sort of attack as the earliest symptom noted. It would be a mistake to assume that any given case is retrobulbar neuritis just because there is a central scotoma. Similar scotoma may be caused by toxic amblyopia, macular hemorrhage, central chorio-retinitis, angiospasm and even senility, but when these are ruled out such patients should be given a guarded prognosis and should be referred to the neurologist.

Opaque nerve fibres in the retina present a picture that is startling to one not doing routine ophthalmoscopy. In the orbit the optic nerve is nearly twice as large as it is where it pierces the choroid, due to the fact that in the orbital portion each nerve fibre is coated or insulated by its myelin sheath, and this sheath ends abruptly where the nerve pierces the sclera. So the nerve-fibres within the eye are naked and transparent. Sometimes a small bundle of fibres retain their sheaths after entering the eye, producing a white patch of variable extent, usually adjacent to the disk, and at the edge of this patch fine radial striations may be seen. This might easily be mistaken for exudate, and, conversely, a patch of exudate might be thought to be opaque fibres, so if there is any doubt, it should be passed on by an ophthalmologist. The condition is developmental, not progressive, causes only an enlargement of the blind spot, and treatment is not indicated or possible.

These have been merely some rambling remarks about some of the commoner conditions that call for coöperation between the oculist and the general practitioner. I have said what I thought should or should not be done in each case. In the following I don't know just what should be done, and I am asking you, especially the general practitioner to advise me. The problem is one of professional ethics.

In every city there are a few physicians who do not keep up with modern advances in medicine but continue to practice the brand of medicine they were taught at school. If such a one should refer a patient to me, and I should find an ocular condition which indicated a meticulous physical and clinical work-up, should I refer such a case back to him for work that I know is beyond his ability? If I do refer him back, I have not given the patient the best advice, and if I refer him elsewhere I have not been square with the doctor, and have doubtless made an enemy for life.

315 Medical Arts Building.

Schering Wins Advertising Honors.

The direct mail advertising of the Schering Corporation of Bloomfield and Union, N. J., has recently been awarded the "Best of Industry" prize by the Direct Mail Advertising Association, which has in the past six years consistently honored Schering as one of the "50 Direct Mail Leaders" of the country. Announced at the group's annual convention at Cleveland, Ohio, the selection of Schering's promotional campaign for the past year is in recognition of the effective force of the Company's direct mail program of information for the medical profession. Artistic excellence, quality production and high calibre of copy have marked the Schering service as outstanding for almost a decade.

MEDICAL PUBLIC RELATIONS*

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It is assumed that every member of the Medical Society of Virginia is interested in Medical Public Relations. Perhaps such questions as the following are being discussed by many of you.

First, what is Medical Public Relations? What is its program in Virginia? What has it undertaken? What it its future program in our State and how can the local society and individual doctor assist in facilitating this?

Public Relations refers to those things that take place or exist between, or among, two or more parties. An opinion held, an attitude developed, an event or an activity; any or all of these may be effected by Public Relations. Boiled down, so to speak, it may be said that approval or disapproval and acception or rejection are perhaps of paramount concern in Public Relations. Another way of expressing it might be the focusing of any divergencies in points of view. These opinions, attitudes, activities or events can be good or bad, desirable or undesirable.

Of all the things that Public Relations may be said to be we can point to one thing that it certainly is *not*, that is PUBLICITY.

I have tried to study Philosophies of Public Relations and am of the opinion the Public Relations Program that is confined to PUBLICITY is a short-sighted one that will not pay long term dividends. Our concern in Medical Public Relations is not confined to the attitude of the Public toward the doctor, but also of the doctors of Medicine toward the public. And incidentally, we are also interested in professional relations. That is to say, the relationship between, and among, the Doctors of Medicine.

The ramifications of our civilization are so complex, affected by so many organized forces and subject to such constant change, that it may be unwise for any agency or professional group not to be concerned over the relationship it enjoys with those whom it serves.

This should not be construed to even imply that the merits of any Doctor should be advertised. But, Doctors of Medicine have accomplished too much in medical science, and have rendered too much service to humanity, to permit that the medical profession of our day be misunderstood, or that they not be understood by those served, by those who pay the bills, and even by those who influence the laws affecting our health and medical care. It seems to follow that a real responsibility exists to explain to the public the merits of our present system of health and medical care and the demerits of any Health and Medical Care Program that is controlled by laymen or politicians.

If our present system of medical care or our Medical Profession are not understood by any segment of the public today, it is not because of wilful neglect, or because of medical indifference, but perhaps more because of a matter of preoccupation on the part of the physician in the practice of his profession. As we listen to lay opinions, observe articles in publications, or look in the direction of our National Government headquarters, we believe one can sense a greatly increased interest in matters of health and medical care. It might also be said that the public individually and through organized segments are expressing more freely their views on this matter and indeed showing some initiative in proposing a system that is preferred, at least by some, to our present one.

We believe that the interests of those who would like to change our present system of health and medical care have become so well organized and so well represented by personnel and dollars that the time has arrived, if the hour is not indeed late, for those responsible for our present system of medicine to take cognizance of their responsibility in the retention and still further development of the system of medical care that will unquestionably serve the best interests of our people. Mere acquiescence, or simply the adoption of resolutions, is not sufficient. We have indicated that Public Relations should be a positive influence. If it is to be successful, the active support of our State organization, Local Medical Societies, the Women's Auxiliary to the

*Read at the annual meeting of the Medical Society of Virginia in Roanoke, October 13, 1947.

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Medical Society, and that of every individual Doctor of Medicine is needed.

I shall at least not make the mistake of underestimating the power, the leadership, and the influence that our Medical Profession possesses. Although some of these assets may have lain much too dormant in the past they are truly potentially great and should be awakened and directed into active and constructive channels. There is ample evidence that this can be done and in such a manner as to constitute good Public Relations.

As we observe the trends of programs and activities of Medical Public Relations in this country, we believe that the Medical Society of Virginia is to be congratulated on the place this subject is being given in the interest, activities and support of the membership of our Medical Society. We, in Virginia, are young in this undertaking and do not claim the only program, or the best program of any State in the Union, but you do have reason to feel proud of the beginning you have made in an approach to a sound program. This we should refer to only as a means of encouragement to the end that our people shall have more and better medical care under our present system.

As we think of some of our activities we should keep in mind that your program is recommended by your Public Relations Committee and endorsed by your Council and House of Delegates; that your policy, and in so far as is possible, the content is studied carefully by your Public Relations committee, or authorized agency of the Medical Society, and checked by your Medical Censorship Board, consisting of five outstanding members of your Society. I do not hesitate to recommend the continuation of this procedure.

If time permitted I should be glad to discuss with you more in detail some of the activities of your Public Relations such as:

1. Meetings with Local Medical Societies, their work and suggestions they have made
2. The office of the members of the District Council and their work
3. Veterans Medical Care Program
4. Our interest in Legislation State and Federal
5. Compiling a list of Doctors in Virginia
6. Our Radio Program
7. Our relationship with the Press
8. Our Plans for the Future and
9. Some of our problems

Many of these things are brought to your attention through your Journal and we hope that each of you will devote at least a few minutes of your time while you are here at our little Exhibit with the view of indicating what literature you would like and give us any suggestions for the improvement of the Exhibit.

I should like to thank the President of the Medical Society of Virginia, your program committee, and any others who helped in affording me the opportunity of this appearance and to assure each of you that I am deeply conscious of the assistance you can give the Public Relations Committee and my office in the future.

If I were to leave one recommendation with you it would perhaps be to the effect that each Local Medical Society, each Councilor, each member of the District Council and each member of the Medical Society of Virginia and the Woman's Auxiliary view this whole matter of Public Relations as a personal responsibility and challenge to each of us.

If I were to make a prediction it would perhaps be that your program will be only as successful as you want it to be and will be only as effective as you are willing to organize for, and carry on thru the grass roots activities of your local Medical Societies.

And if I had a wish, as we turn a century of medicine in this country, it would be that the doctors of this great land of ours who have passed on might know of the gratitude in the hearts of our people for the development in medical science and the unparalleled humanitarian service rendered by doctors of medicine who loved their profession and who were devoted to its cause.

CORRESPONDENCE

Infectious Hepatitis*

TO THE EDITOR:

I practiced in China and there was an infectious liver trouble, the same or similar to the one reported in the October MONTHLY.

The effect on pregnant women is not mentioned. *Every pregnant woman died of hemorrhage.* Ten died in one small village—treated oriental fashion—but treated along western lines, I had five cases and all lived. The Chinese said it was the Lord's blessing and no doubt it was.

ANNE HOUSTON PATTERSON, M. D.

R.F.D. 2,
Staunton, Virginia
October 16, 1947.

*Infectious Hepatitis. M. M. Pinckney, M.D., J. O. Burke, Jr., M.D., W. T. Thompson, M.D., and H. St. Geo. Tucker, M.D., Richmond, Va., *Virginia Medical Monthly* **74**:443-447, October, 1947.

WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF VIRGINIA

President.....MRS. J. L. DECORMIS, Accomac
President-Elect.....MRS. R. M. REYNOLDS, Norfolk
Recording Secretary.....MRS. M. H. HARRIS, West Point
Corresponding Secretary MRS. HOLLAND TROWER, Eastville
Treasurer.....MRS. REUBEN SIMMS, Richmond
Parliamentarian.....MRS. E. LATANE FLANAGAN, Richmond
Historian.....MRS. H. A. LATANE, Alexandria

The Auxiliary to the Northern Neck Medical Society

Met on October 23rd at Tides Inn, Irvington, with a large attendance. Mrs. Paul Pearson, who has served as president for two years, welcomed two new members, making a total membership of eighteen.

Mrs. A. B. Gravatt, Jr., gave a full report as delegate to the State meeting held in Roanoke. The group then had the privilege of having Mrs. P. Moncure Chichester of Richmond as guest speaker.

Preceding lunch, Mrs. Lee Liggan recited the poem, "Welcome to the Northern Neck".

During the afternoon session, Mrs. R. E. Booker was installed as the new president. Many of the ladies remained for the banquet as guests of the doctors.

MRS. V. L. LITSINGER,
Editorial Chairman.

The Auxiliary to the Northampton-Accomac Medical Societies

Held its Fall meeting on October 22nd, at the home of Mrs. H. L. Denoon at Nassawadox, with Mrs. E. W. P. Downing as co-hostess. There was an attendance of eighteen members and one guest. A delightful luncheon preceded the business meeting, at which the President, Mrs. B. N. Mears, presided. Minutes of the April meeting, the treasurer's report, and an account of the July picnic at Silver Beach were given, and notes were read from principals of the Northampton and Accomac High Schools, thanking for the gift subscriptions to "Hygeia". The president then gave her yearly report, and expressed appreciation to Mrs. J. L. DeCormis, for her help and the interesting reports she had given from other auxiliaries. Mrs. Mears then turned the meeting over to the new president, Mrs. S. K. Ames of Cape Charles, who gave an interesting account of the State meeting.

The Nominating Committee reported the following officers for the coming year: President, Mrs. S. K. Ames, Cape Charles; vice-president and president-elect, Mrs. W. J. Sturgis, Sr., Nassawadox; treasurer for two years, Mrs. J. Fred Edmonds, Accomac; secretary, Mrs. Charles T. Garcia, Cape Charles; recording secretary, Mrs. Holland Trower, Eastville.

The meeting then adjourned to meet in January at the home of Mrs. J. Fred Edmonds in Accomac.

CATHERINE R. TROWER
(MRS. HOLLAND)
Chairman, Press and Publicity.

XUM

PROCEEDINGS
MEDICAL SOCIETY OF VIRGINIA

ANNUAL MEETING
Roanoke
October 13, 14, and 15, 1947

The Medical Society of Virginia held its 100th meeting at Hotel Roanoke, Roanoke, Virginia, on Monday, Tuesday and Wednesday, October 13, 14 and 15, 1947, under the presidency of Dr. William L. Powell of that city. There was a registered attendance of five hundred and eighty-four doctors, one hundred and seventy-one ladies, and eighty-six technical exhibitors. In addition to several business sessions, there was a general session on Monday evening, and six scientific sessions. Social features added to the enjoyment of the meeting.

Scientific Sessions

Section A

Monday, October 13

Section A of the Medical Society of Virginia met in the ballroom of Hotel Roanoke, on Monday afternoon, October 13, beginning at two forty-five o'clock. Vice-President A. B. Hodges of Norfolk called the meeting to order and presided.

The first paper, on "The Psychosomatic Effects of Chronic Invalidism" (illustrated by lantern slides), was read by Dr. David C. Wilson of Charlottesville. Dr. Walter B. Martin of Norfolk opened the discussion which was closed by Dr. Wilson.

Dr. John F. Williams of Richmond read his paper entitled "Practice of Psychosomatic Medicine", which was discussed by Dr. R. C. Siersema, Richmond, and in closing by Dr. Williams.

Dr. Homer E. Ferguson, Richmond, read his paper entitled "The Use of Vitamin E in Menopausal Syndrome", which was discussed by Dr. John F. Williams of Richmond.

The paper of Drs. James B. Black, Jr., J. Warrick Thomas, W. Randolph Graham, and DuPont Guerry, III, of Richmond, on "Varied Allergic Reactions to Penicillin" was read by Dr. Thomas and was discussed by Dr. Oscar Swineford of Charlottesville.

Dr. W. Ambrose McGee, Richmond, read his paper entitled "Advantages of Indirect Skin Tests for Young Allergic Children". This was discussed by Dr. Leta J. White of Petersburg.

Dr. J. W. Love, Alexandria, read his paper entitled "The False Positive Serological Test". This paper was discussed by Dr. E. E. Barksdale, Washington, D. C., and by Drs. D. C. Smith of Charlottesville, R. D. Kimbrough of Richmond.

The program having been completed, the afternoon session adjourned.

Section B

Monday, October 13

Section B of the Society met in Parlor B of Hotel Roanoke at 2:30 p.m. on Monday, October 13, with Dr. W. L. Powell presiding.

The first paper on this program was one on "Results of Vagotomy" by Dr. S. D. Blackford and Dr. Alexander McCausland of Charlottesville.

Dr. Guy W. Horsley of Richmond presented the next paper, entitled "The Treatment of Peptic Ulcer", which was discussed by Dr. R. L. Payne of Norfolk and Dr. S. D. Blackford of Charlottesville.

A paper on "Diagnosis and Treatment of Diverticulitis of the Colon" by Drs. Carrington Williams, Sr. and Jr., of Richmond, was presented by Dr. Williams, Jr., and was discussed by Dr. Ben Rawles of Richmond and by Dr. Williams, Sr., in closing.

Dr. Herbert C. Lee of Richmond next read his paper on "The Use of Early Rising and Early Ambulation Following Surgical Operations", illustrated by lantern slides. This was discussed by Dr. C. Bruce Morton of Charlottesville, Dr. E. T. Trice of Richmond, Dr. Hugh H. Trout of Roanoke, and by Dr. Lee in closing.

"Roentgen Therapy and Bursitis" by Dr. Fred M. Hodges and Dr. Randal A. Boyer of Richmond was the next subject presented, and this was discussed by Dr. J. L. Tabb, Richmond, Dr. Claude Moore, Washington, D. C., Dr. J. H. Selby, Alexandria, and in closing by Dr. Boyer.

The last paper on the program was by Dr. Donald S. Daniel, Richmond, on "Thrombosis of the Deep Veins of the Lower Extremity". This was discussed by Drs. Wellford Reed, Richmond, J. Bolling Jones, Petersburg, and E. T. Trice of Richmond.

Adjournment followed.

General Session

Monday, October 13

The first general session of the Medical Society of Virginia was held in the ballroom of the Hotel Roanoke, beginning at 8:30 P.M., Monday, October 13, 1947.

Dr. Frank A. Farmer of Roanoke, Chairman of the Committee on Arrangements, called the meeting to order, and Reverend Harry Y. Gamble of that city pronounced the invocation.

CHAIRMAN FARMER: I speak as only one member of the Roanoke Academy of Medicine when I say it is a pleasure to have the meeting of the Medical Society of Virginia here. It has always been a pleasure and an honor to have these medical gatherings in Roanoke.

The Medical Society of Virginia was organized in 1820 and had its first meeting in 1821. Many years passed without meetings, due to wars and other causes, and this is the one-hundredth annual meeting. At the end of this session there will be a birthday party in the other end of this hall. Miss Edwards, our Executive Secretary, has gotten together photographs of quite a number of the men who have served as president down through the years and has them on display just outside this hall.

(Dr. Farmer then made some announcements about the entertainment features of the program and about the exhibits.)

CHAIRMAN FARMER: During the twenty-five years that I have been attending the meetings of this Society, one man, to my knowledge, has never missed a meeting. He has at one time or another served on every committee and in every office, appointive or elective. In other words, whenever there was real work he was selected to do it and in my opinion he has done more work for this Society than any other man in the membership. I have the honor of presenting to you Roanoke's own Dr. William L. Powell, President of the Medical Society of Virginia.

PRESIDENT POWELL: Dr. Farmer, distinguished guests, ladies and gentlemen, I feel deeply honored in being the presiding officer of the Medical Society of Virginia at this its one-hundredth meeting.

Dr. Powell then read his Presidential Address.

PRESIDENT POWELL: It is our custom at each meeting of the Medical Society of Virginia to have a memorial hour in which the names of those who passed on during the previous year are read. I call now on Dr. B. E. Harrell of Norfolk to conduct our memorial hour.

DR. B. E. HARRELL, Chairman Membership Committee, Norfolk: Ladies and gentlemen, as a tribute to the memory of the members of the Medical Society of Virginia who have passed on since our meeting in 1946, we present their names and the dates of their passing. There are thirty-eight names in this list, and I ask you now to stand while they are read. They are as follows:

MEMBERS WHOSE DEATHS HAVE BEEN REPORTED SINCE 1946 MEETING

Dr. William C. Stephenson, Jr., Roanoke, October 3, 1946.
Dr. Claudius James Riddick, Suffolk, October 18, 1946.
Dr. William Preston Burton, Covington, October 20, 1946.
Dr. John P. Haller, Salem, October 24, 1946.
Dr. Oscar Winfred Carper, Front Royal, October 26, 1946.
Dr. Robert Edward Timberlake, Richmond, October 27, 1946.
Dr. William Oscar Pollard, Speers Ferry, October 28, 1946.
Dr. James Henry Deyerle, Harrisonburg, November 26, 1946.
Dr. Charles R. Vance, Bristol, November 26, 1946.
Dr. Lewis Holladay, Orange, December 10, 1946.
Dr. Flavius Ogburn Plunkett, Lynchburg, December 18, 1946.
Dr. George Franklin Simpson, Purcellville, December 24, 1946.
Dr. Reginald Munson, Linden, December 29, 1946.
Dr. John William Preston, Roanoke, January 1, 1947.
Dr. Joseph Albert Abercrombie, Richlands, January 11, 1947.
Dr. Thomas Benjamin Pearman, Richmond, January 12, 1947.
Dr. Robert Lawrence Mason, Roanoke, January 15, 1947.
Dr. James Alexander Grizzard, Drewryville, January 28, 1947.
Dr. Oscar Hunter McClung, Lexington, February 2, 1947.
Dr. William Seddon Cox, West Point, February 11, 1947.
Dr. William Miller Holman, Lee, February 22, 1947.
Dr. John Edward Hamner, Petersburg, February 24, 1947.
Dr. John Aldridge Gibson, Leesburg, March 9, 1947.
Dr. Max Schoenbaum, Richmond, March 28, 1947.
Dr. James John Bishop, Ivanhoe, March 30, 1947.
Dr. William Clyde West, Alexandria, April 1, 1947.
Dr. Henry Rolfe DuPuy, Winchester, May 3, 1947.
Dr. Otis Hillsman Whitlock, Richmond, May 9, 1947.
Dr. Alfred D. Henkel, Winchester, May 27, 1947.
Dr. Jesse Hill Crouch, Richmond, June 13, 1947.
Dr. Hugh Page Newbill, University, June, 1947.
Dr. Carroll Harris Fowlkes, Richmond, July 6, 1947.
Dr. William Thomas Potter, Norfolk, July 17, 1947.
Dr. William Harvey Bruce, Dungannon, July 27, 1947.
Dr. Claude Bernard Bowyer, Stonega, July 29, 1947.
Dr. James Henry Ferguson, Clifton, August 1, 1947.
Dr. Walter Ashby Plecker, Richmond, August 2, 1947.
Dr. Tiffany Johns Williams, University, August 19, 1947.

The assembly stood in silence while the names of the deceased members were read.

PRESIDENT POWELL: Next on our program is a very distinguished Virginian who is Professor of Clinical Medicine at the Medical College of Virginia. He is the editor of three volumes of the "History of Medicine in Virginia", and the author of a book on Physical Diagnosis, a book on Allergy, and of a volume on "Making a Downtown Church". Dr. Wyndham B. Blanton of Richmond will now speak to you on "1820—The Virginia Doctor and His Times".

Dr. Blanton read his paper on the above-named subject.

PRESIDENT POWELL: We are fortunate in having another distinguished guest who was formerly Professor of History at Duke, with a leaning towards medical subjects, especially medicine in the old South. At present Dr. Shryock is Professor of History at the University of Pennsylvania. He is the author of a well-known volume on "History of Medicine" and is the President of the American Association of the History of Medicine. There was a Shryock connected with the early history of Transylvania College, but whether he was an ancester of our guest I know not. I take pleasure in introducing Dr. Richard H. Shryock of Philadelphia.

Dr. Shryock addressed the Society on the subject of "Progress of Medicine in America in the Past One Hundred Years".

PRESIDENT POWELL: I mentioned in my report, earlier in the evening, that we have an efficient Director of Public Relations, Mr. Henry S. Johnson. Mr. Johnson will now address us.

Mr. Johnson read his paper on "Medical Public Relations".

President Powell presented the Past Presidents of the Society who were sitting on the platform, and the meeting then adjourned to enjoy a birthday party and a social hour.

XUM

Scientific Sessions
Section A
Tuesday Morning, October 14

Section A of the Medical Society of Virginia met in the ballroom of the Hotel Roanoke on Tuesday, October 14, and was called to order at 9:10 A.M. by Dr. W. A. Porter of Hillsville, Councilor for the Fifth District, who presided as chairman.

Dr. W. C. Winn of Richmond read his paper entitled "The Clinical Significance of the Rh Factor" (illustrated by lantern slides).

A paper on "Hemolytic Anemia in the Newborn" (with lantern slides) was read by Dr. Edwin L. Kendig, Jr., of Richmond.

The papers of Dr. Winn and Dr. Kendig were discussed by Dr. J. H. Scherer, Richmond, and Mr. Robert Waller, of Medical College of Virginia.

Dr. John S. Weitzel, Richmond, read his paper entitled "Tetanus Neonatorum" (illustrated by lantern slides), which was discussed by Dr. Lee E. Sutton, Jr., of Richmond.

Dr. F. N. Mullen, Jr., Norfolk, read his paper entitled "Factors in Pregnancy Affecting the Newborn", and this was discussed by Dr. Lee E. Sutton, Jr., Richmond, Dr. C. P. Jones, Newport News, Dr. W. Ambrose McGee, Richmond, and in closing by Dr. Mullen.

(During the reading of this last paper Dr. A. B. Hodges, Norfolk, Vice-President, took over as presiding officer.)

The paper of Drs. Lee E. Sutton, Jr., and Harry Y. Spence of Richmond, entitled "The Nutritional Management of the Nephrotic Syndrome" (illustrated by lantern slides), was read by Dr. Spence and was discussed by Dr. H. St. George Tucker, Richmond, and Dr. Basil B. Jones, Richmond.

The paper of Dr. Thomas W. Murrell, Jr., and Dr. Emily Gardner of Richmond, entitled "Infantile Eczema in General Practice", was read by Dr. Murrell and was discussed by Dr. J. Warrick Thomas, Richmond, and Dr. W. Ambrose McGee, Richmond.

Its program having been completed, Section A then adjourned to meet in a general session at twelve o'clock to hear one of the guest speakers. Dr. Powell, president, presided.

PRESIDENT POWELL: We are fortunate in having a very distinguished guest speaker at this time, Dr. W. Halsey Barker of Baltimore, who is a worthy son of a worthy sire. He is Assistant Dean at the Johns Hopkins Medical School and an Assistant Professor. I take pleasure in introducing Dr. Barker, who will speak at this time on "Gastro-Intestinal Symptoms Occurring in Disorders Located Outside of the Gastro-Intestinal Tract".

Dr. Barker then read his address.

Following this, the general session adjourned, at twelve-fifty P.M.

Section B
Tuesday, October 14

Dr. A. B. Hodges, vice-president, presided over this Section at its meeting on Tuesday, October 14, starting at 9:00 a.m.

The first paper on the program was one on "Tic Douloureaux: Review of 200 Cases Treated by Surgery", by Drs. C. C. Coleman, J. M. Meredith, and C. E. Troland of Richmond. This was illustrated by lantern slides.

Dr. Fletcher D. Woodward of Charlottesville presented the next paper—"The Significance of Paralysis of the Larynx", illustrated by lantern slides. Dr. C. T. Burton of Roanoke discussed this paper.

A Paper on "Thyroid Surgery", illustrated by lantern slides, was next presented by Drs. J. W. Devine, Sr., and Jr., of Lynchburg, and it was discussed by Dr. Hugh H. Trout, Jr., Roanoke, Dr. R. L. Payne, Norfolk, Dr. Kinloch Nelson, Richmond, and Dr. T. J. Hughes, Roanoke.

"Hemorrhagic Disorders: Diagnosis and Treatment" by Drs. Byrd S. Leavell and Howard P. Holt of Charlottesville was next read. The discussion was opened by Dr. J. R. Beckwith of Clifton Forge, who was followed by Dr. E. P. Lehman of Charlottesville, and by Dr. Holt in closing.

Dr. J. A. Shield of Richmond read the next paper, entitled "The Diagnosis and Treatment of Neurosyphilis with Negative Blood and Spinal Fluid". This was illustrated by lantern slides and discussed by Dr. Harry Brick of Richmond.

This Section then adjourned to attend the general session at which Dr. W. Halsey Barker was the guest speaker.

Scientific Session
Tuesday Afternoon, October 14
2:30 P.M.

The Medical Society of Virginia met in the ballroom of the Hotel Roanoke with Dr. A. B. Hodges, Vice-President, presiding.

Dr. William H. Harris, Richmond, read his paper entitled "Progress Report of the Cooperative Study of Streptomycin in Clinical Tuberculosis" (with lantern slides), which was discussed by Dr. George A. Welchons, Richmond.

The paper of Drs. Dudley C. Smith and Robert F. Thompson of Charlottesville, entitled "The Management of Early Syphilis" (illustrated by lantern slides), was read by Dr. Smith and was discussed by Dr. W. W. S. Butler of Roanoke.

(During the reading of the last-named paper, President William L. Powell took the Chair.)

President Powell spoke as follows "Gentlemen, we are very fortunate in having with us a distinguished guest who is head of the Surgical Department of the University of Michigan at Ann Arbor, and who will now speak to us on 'Peripheral Vascular Diseases and Newer Concepts of their Management' ".

Dr. Coller gave an illustrated address on the above-named subject.

The President thanked Dr. Coller for his splendid ad-

dress, and then Dr. Hodges resumed the duties of chairman.

The paper of Drs. William A. Read and Russell Buxton of Newport News, entitled "Gout Simulating Rheumatoid Arthritis" (with lantern slides), was read by Dr. Read and was discussed by Dr. Buxton.

Dr. William R. Jordan, Richmond, read his paper entitled "Pregnancy and Diabetes", which was discussed by Dr. Waverly R. Payne of Newport News.

The paper of Dr. Chester D. Bradley and Miriam D. Bradley, R. N., of Newport News, entitled "Medical Practice on the Virginia Peninsula Sixty Years Ago", was read by Dr. Bradley and was discussed by Dr. M. P. Rucker, Richmond.

The program having been completed, the afternoon session then adjourned, at five-thirty P.M.

Scientific Session

Wednesday Morning, October 15

The Medical Society of Virginia met in the ballroom of the Hotel Roanoke on Wednesday morning, October 15, for its final session and was called to order by the President, Dr. William L. Powell.

The paper of Drs. Allen E. LeHew and Julian R. Beckwith of Clifton Forge, entitled "Review of 100 Cases of Coronary Thrombosis with Myocardial Infarction" (illustrated with lantern slides), was read by Dr. Beckwith and was discussed by Dr. J. Edwin Wood, Jr., of Charlottesville and Dr. Oscar Swineford, Charlottesville, and in closing by Dr. Beckwith.

The paper of Drs. A. J. Crutchfield, Jr., and J. Edwin Wood, Jr., of Charlottesville, entitled "The Role of Ammonium Chloride and Other Acid-Producing Substances in the Treatment of Congestive Heart Failure" (illustrated with lantern slides), was presented by Dr. Crutchfield and was discussed by Dr. R. Earle Glendy of Roanoke and Dr. Paul D. Camp of Richmond.

Dr. R. Earle Glendy of Roanoke read his paper entitled "Rheumatic Disease in Southwestern Virginia" (with lantern slides), which was discussed by Dr. William M. Moir, Roanoke.

A paper entitled "The History—An Important Factor in Diagnosis of Coronary Thrombosis" was read by Dr. Ernest L. Copley, Richmond, and was discussed by Dr. Paul D. Camp of Richmond.

Dr. K. D. Graves, Roanoke, read his paper on "Treatment of Bronchial Asthma" (illustrated by lantern slides), which was discussed by Dr. Oscar Swineford, Charlottesville, and by another member and in closing by Dr. Graves.

The paper of Drs. Reno H. Porter and Nathan Bloom of Richmond, entitled "The Practical Application of Unipolar Leads in Clinical Electrocardiography" (with lantern slides), was read by Dr. Porter and was discussed by Dr. R. Earl Glendy, Roanoke.

President Powell presented Mr. Frank E. Smith, Director Associated Medical Care Plans, American Medical Association, Chicago, Illinois, who gave a most interesting talk on "The Doctor Assumes a Moral Responsibility".

PRESIDENT POWELL: The time has come for the parting of the ways. Will Dr. Robertson and Dr. Farmer assist the incoming President, Dr. Guy R. Fisher, to the rostrum?

Dr. Fisher, I congratulate you upon assuming this office. You have a fine council and a fine Executive Secretary. It is a great pleasure for me to turn over this gavel to much more efficient hands. I present Dr. Fisher.

DR. GUY R. FISHER, Staunton, President: President Powell and fellow members, I am deeply grateful for this great honor which you have bestowed upon me and of which I am so unworthy. I enter upon my task as President of this Society considering it not an onerous duty but a high privilege to serve you as best I can. This year this organization shall not be an "I" medical society but a "we" cooperative effort. I covet your counsel, your support, your cooperation; and in my tenure of office I assure you everything I do I hope will be predicated upon the beautiful principles of the Sermon on the Mount. My fellow members, I trust that when the sun shall set upon my administration the Medical Society of Virginia, with your help, shall have had higher achievements, shall have had greater accomplishments than ever before, and that it shall be a year of the most cohesive, most cooperative effort in our history, and that we shall see the fruition of all the ideals we hope to attain in the practice of medicine. I thank you.

It is the law of the Society that the President appoint new members of the standing committees, and that now becomes my pleasant duty. As you will see from the JOURNAL, a number of the committeemen will continue to serve, because the tenure of office is from one to three years. I shall now read only my appointments and leave for further publication in our JOURNAL the full committees.

There being no further business, the Medical Society of Virginia adjourned at 12:45 p.m., October 15, 1947, *sine die*.

Standing Committees

(Numbers after names indicate length of term of office, as the By-Laws provide that new members of Standing Committees shall be named by the incoming President for terms of three years, except in the case of the Department of Clinical and Medical Education.)

PUBLICATION AND PROGRAM: M. P. Rucker, M.D. (1), Richmond, *Chairman;* Wyndham B. Blanton, M.D. (2), Richmond; Alex. F. Robertson, Jr., M.D. (3), Staunton.

SCIENTIFIC EXHIBITS AND CLINICS: V. W. Archer, M.D. (2), University, *Chairman;* W. Ambrose McGee, M.D. (3), Richmond; H. F. Dormire, M.D. (1), Virginia Beach.

DEPARTMENT OF CLINICAL AND MEDICAL EDUCATION: W. L. Powell, M.D., Roanoke, *Chairman;* George B. Zehmer, Richmond, *Executive Secretary;* L. J. Roper, M.D., Richmond, State Health Commissioner; S. D. Blackford, M. D., University of Virginia, Charlottesville; C. M. Caravati, M.D., Medical College of Virginia, Richmond; James W. Love, M.D., Alexandria; Julian L. Rawls, M.D., Norfolk.

LEGISLATION: W. C. Caudill, M.D. (2), Pearisburg, *Chairman;* Dean B. Cole, M.D. (3), Richmond; Frank

A. Farmer, M.D. (2), Roanoke; James R. Gorman, M.D. (2), Lynchburg; Carrington Williams, M.D. (1), Richmond; J. D. Hagood, M.D. (3), Clover; G. C. Tyler, M.D. (1), Newport News; C. C. Smith, M.D. (1), Norfolk; P. W. Boyd, M.D. (3), Winchester.

MEDICAL ECONOMICS: J. T. T. Hundley, M.D. (1), Lynchburg, *Chairman;* James P. Williams, M.D. (3), Richlands; Walter B. Martin, M.D. (1), Norfolk; H. H. McGuire, M.D. (2), Winchester; George S. Hurt, M.D. (2), Roanoke; J. B. McKee, M.D. (3), Winchester.

MEMBERSHIP: B. E. Harrell, M.D. (2), Norfolk, *Chairman;* J. Boling Jones, M.D. (1), Petersburg; A. M. Showalter, M.D. (3), Christiansburg.

ETHICS: J. L. Hamner, M.D. (3), Mannboro, *Chairman;* K. D. Graves, M.D. (2); Roanoke; R. L. Raiford, M.D. (1), Franklin.

JUDICIAL: J. Morrison Hutcheson, M.D. (3), Richmond, *Chairman;* Hugh H. Trout, M.D. (2), Roanoke; P. St. L. Moncure, M.D. (1), Norfolk.

Special Committees

PUBLIC RELATIONS AND MEDICAL SERVICE: J. M. Emmett, M.D., Clifton Forge, *Chairman;* H. B. Mulholland, M.D., Charlottesville; L. J. Roper, M.D., Richmond.

RURAL HEALTH: H. B. Mulholland, M.D., Charlottesville, *Chairman;* E. C. Jamison, M.D., Rocky Mount; W. R. Pretlow, M.D., Warrenton; L. J. Roper, M.D., Richmond.

CHILD WELFARE: Emily Gardner, M.D., Richmond, *Chairman;* J. M. Bishop, M.D., Roanoke; W. T. Graham, M.D., Richmond; R. B. Hightower, M.D., Alexandria; Mary E. Johnston, M.D., Tazewell; F. N. Mullen, M.D., Norfolk; W. W. Waddell, M.D., Charlottesville; J. B. Stone, M.D., Richmond.

MATERNAL HEALTH: C. J. Andrews, M.D., Norfolk, *Chairman;* A. L. Carson, M.D., Richmond; G. N. Carter, M.D., Boydton; A. M. Groseclose, M.D., Roanoke; J. M. Nokes, M.D., Charlottesville; C. A. Nunnally, M.D., Fredericksburg; Waverly R. Payne, M.D., Newport News; Glenn Campbell, M.D., Staunton; M. Pierce Rucker, M.D., Richmond; L. L. Shamburger, M.D., Richmond.

WALTER REED COMMISSON: Clarence Porter Jones, Sr., M.D., Newport News, *Chairman;* J. D. Clements, M.D., Ordinary; James W. Smith, M.D., Hayes Store.

TO CONFER WITH STATE BOARD OF NURSE EXAMINERS: I. A. Bigger, M.D., Richmond, *Chairman;* W. C. Akers, M.D., Stuart; Russell Buxton, M.D., Newport News; J. A. Gooch, M.D., Alexandria; A. P. Jones, M.D., Roanoke; C. Bruce Morton, M.D., Charlottesville; F. B. Teague, M.D., Martinsville; C. R. Titus, M.D., Bedford; S. H. Garst, M.D., Staunton.

VENEREAL DISEASE CONTROL: W. W. S. Butler, M.D., Roanoke, *Chairman;* David S. Garner, M.D., Roanoke; L. J. Roper, M.D., Richmond; Raymond Kimbrough, M.D., Richmond; James W. Love, M.D. Alexandria; D. C. Smith, M.D., Charlottesville; Richard Fowlkes, M.D., Richmond.

TUBERCULOSIS: C. Lydon Harrell, M. D., Norfolk, *Chairman;* Frank B. Stafford, M.D., Charlottesville; J. B. Nicholls, M.D., Catawba Sanatorium; Charles W. Scott, M.D., Burkeville.

MENTAL HYGIENE: Frank H. Redwood, M.D., Norfolk, *Chairman;* J. E. Barrett, M.D., Richmond; R. Finley Gayle, M.D., Richmond; James P. King, M.D., Radford; David C. Wilson, M.D., Charlottesville; J. B. Pettis, M.D., Staunton.

CANCER: George Cooper, Jr., M.D., Charlottesville, *Chairman;* I. A. Bigger, M.D., Richmond; C. W. Eley, M.D., Norfolk; A. B. Gathright, Jr., M.D., Richmond; E. P. Lehman, M.D., Charlottesville; Wm. H. Parker, M.D., Charlottesville; Julian L. Rawls, M.D., Norfolk; Mason Romaine, M.D., Richmond; L. J. Roper, M.D., Richmond; Herbert Wolff, Jr., M.D., Alexandria; George Z. Williams, M.D., Richmond.

INDUSTRIAL HEALTH: H. U. Stephenson, M.D., Richmond, *Chairman;* W. B. Barton, M.D., Stonega; M. W. Healy, M.D., Norfolk; J. V. Jordan, M.D. Covington; Alexander McCausland, M.D., Charlottesville; C. L. Savage, M.D., Waynesboro; T. J. Tudor, M.D., Norton; James Elliott, M.D., Lebanon.

NUTRITION: McLemore Birdsong, M.D., Charlottesville, *Chairman;* George H. Carr, Jr., M.D., Portsmouth; Edwin A. Harper, M.D., Lynchburg; A. B. Hodges, M.D., Norfolk; E. G. Scott, M.D., Lynchburg; C. C. Powel, M.D., Harrisonburg.

ADVISORY TO WOMAN'S AUXILIARY: S. K. Ames, M.D., Cape Charles, *Chairman;* George S. Hurt, M.D., Roanoke; P. W. Miles, M.D., Danville; H. A. Latane, M.D., Alexandria; Reuben Simms, M.D., Richmond.

REHABILITATION: Roy M. Hoover, M.D., Roanoke, *Chairman;* Paul D. Camp, M.D., Richmond; George A. Duncan, M.D., Norfolk; J. R. Blalock, M.D., Marion; N. F. Rodman, M.D., Norfolk; L. J. Roper, M.D., Richmond; G. B. Setzler, M.D., Pennington Gap; Leroy Smith, M.D., Richmond; Frank B. Stafford, M.D., Charlottesville; W. E. Dickerson, M.D., Danville; G. S. Fitz-Hugh, M.D., Charlottesville; F. J. Wright, Jr., M.D., Petersburg.

NATIONAL EMERGENCY MEDICAL SERVICE: John Powell Williams, M.D., Richmond, *Chairman;* Guy Richardson, M.D., Bristol; R. P. Bell, Jr., M.D., Staunton; W. H. Chapman, M.D., Suffolk; Beverley F. Eckles, M.D., Galax; J. M. Hurt, M.D., Blackstone; Frank A. Farmer, M.D., Roanoke.

CONSERVATION OF HEARING: P. N. Pastore, M.D., Richmond, *Chairman;* Fletcher Woodward, M.D., Charlottesville; H. Grant Preston, M.D., Harrisonburg; C. C. Cooley, M.D., Norfolk; Mortimer Williams, M.D., Roanoke; T. M. Winn, M.D., Covington.

BUSINESS SESSIONS

Council

Special Meeting

A special meeting of the Council was held at the Hotel Roanoke on Sunday, October 12th, at 8:30 P.M. Dr. W. L. Powell, President, presided with others in attendance as follows: Dr. Guy Fisher, president-elect; Dr. A. B.

Hodges, vice-president; Drs. R. B. Bowles, C. L. Harrell, Carrington Williams, J. L. Hamner, W. A. Porter, W. R. Whitman, J. E. Knight, and F. H. Smith, councilors; Dr. M. P. Rucker, editor of the MONTHLY; Dr. L. J. Roper, State Health Commissioner; and Dr. W. B. Martin.

The purpose of this meeting was to receive a report of the survey of hospitals and hospital facilities in Virginia as provided by the Hill-Burton Bill. Dr. Roper introduced Mr. A. Gibson Howell, director of the Commission appointed by Governor Tuck to make this survey. He stated that Virginia is naturally divided into six trade areas which will be used as regional centers. These centers are Richmond, Norfolk, Roanoke, Charlottesville, Alexandria and Danville. Their recommendations include plans for hospitals and additions to present hospitals in these centers, these to be lined up with smaller area centers and hospital communities. The intermediate area hospital would be from 150 to 200 beds and the rural hospitals from 50 to 75 beds. It is estimated that 4.6 beds per 1,000 population are needed. There were 6,870 approved beds in Virginia, and an additional 5,875 are needed in general hospitals. There are 3,848 acceptable hospital beds in mental institutions in Virginia, with 5,386 unacceptable beds. It is proposed that there be 8,857 new mental beds and a 400-bed alcoholic hospital. There was also a recommendation of a new hospital for colored tuberculosis patients to be located in Richmond and an increase in the capacity of existing sanatoria. Establishment of two chronic disease hospitals—one in Richmond and one in Charlottesville—is also recommended. Mr. Howell stated that this survey was made only to point out the need for hospital services in Virginia. His report has been approved by the Virginia Hospital Association and the Virginia Graduate Nurses Association and will be presented at a public hearing for approval before being presented the Federal Government. One-third of the funds necessary for this work will be furnished by the Federal Government but the other two-thirds must be made up by the community and state.

After a discussion, Dr. Harrell moved the approval of this plan in principle. Seconded and carried.

The special meeting then adjourned.

Regular Meeting

The regular meeting of the Council was called to order by the President, Dr. Powell, at the Hotel Roanoke, October 13th, at 9:30 A.M. The following were present: Dr. Fisher, president-elect; Dr. Julian L. Rawls, immediate past president; Dr. Hodges, vice-president; Drs. Bowles, Harrell, Williams, Hamner, Porter, Whitman, A. F. Robertson, Knight, and Smith, councilors; Dr. Rucker, editor, and Dr. Roper, State Health Commissioner.

The minutes of the Executive Session of the Council, held on May 24, 1947, were read by the secretary and approved.

The minutes of the January meeting, published in the March issue of the VIRGINIA MEDICAL MONTHLY, were also approved as published.

The budget as prepared by Drs. Williams, Harrell and Whitman, was then presented as follows:

BUDGET—OCTOBER 1, 1947—SEPTEMBER 30, 1948

EXECUTIVE OFFICE	PROPOSED
Salaries	$ 6,400.00
Bonuses	600.00
Office Rent	600.00
Telephone and telegrams	200.00
Stationery and office supplies	175.00
Repairs and replacements	150.00
Postage	300.00
Audit Fee	90.00
Social Security tax	60.00
State Convention expense	700.00
Delegates to A.M.A.	600.00
Councilors and Secretary's expense	100.00
President's expense	100.00
President-Elect's expense	50.00
Special Appropriations	500.00
Miscellaneous	75.00
Virginia Medical Monthly	13,000.00
Walter Reed Commission	75.00
Clinical and Medical Education	1,200.00
Maternal Health	25.00
Cancer Control	175.00
Scientific Exhibits	750.00
President's Contingent Fund	500.00
Va. Council on Health and Medical Care	500.00
New Filing System	350.00
	27,275.00
PUBLIC RELATIONS DEPARTMENT	
Salary—Director	7,000.00
Salaries—Personnel	3,000.00
Traveling expense	2,000.00
Conferences	1,000.00
Radio programs	3,500.00
Press—Materials	4,000.00
Printing, literature and bulletins	3,000.00
Telephone and telegrams	1,000.00
Office Rent	600.00
Stationery and office supplies	500.00
Postage	1,000.00
Office equipment	500.00
Miscellaneous	1,000.00
	28,100.00
TOTAL	$55,375.00

Dr. Rawls asked if the Council had ever considered a retirement fund for employees of the executive office, and moved that the budget committee look into the feasibility of establishing such a fund. Seconded and carried.

Dr. Harrell moved that the Public Relations Committee be permitted to change the appropriations of that department from one feature of their work to another when found necessary. Seconded. Dr. Williams moved that items be shifted at the discretion of the budget committee. Seconded and carried.

XUM

Dr. Porter moved that the budget committee be requested to report to the Council at its next meeting with regard to the retirement fund. Carried.

The budget was approved as presented.

Dr. Knight presented the following resolution:

WHEREAS a major part of the military medical work during time of war is of a necessity done by civilian doctors in uniform, the Medical Society of Virginia does not consider it remiss that it interest itself in medical problems and policies concerning the Armed Forces, and

WHEREAS the incorporation of women in the Armed Forces, in functions other than the Nurses Corps, presents a new military medical problem, and

WHEREAS when a woman enters the military organization she surrenders her right to choose her own doctors.

THEREFORE, BE IT RESOLVED that we, the Medical Society of Virginia, go on record as approving the efforts made by Senator Harry F. Byrd during the last session of Congress to secure specialist medical care for military women in problems peculiar to the female, and further that we request Senator A. Willis Robertson, and all the members of Congress from Virginia to assist in this effort and, if such effort be impossible of accomplishment in its present form, that the above named Senators and Congressmen from Virginia be urged to work towards the accomplishment of this goal (the proper medical care of military women in problems peculiar to the female) by some other legislative means, such as the appointment of a consultant of high rank to the Surgeon General's office and in the corresponding medical services of the Navy and Air Corps, who shall be a doctor of prominence in the field of medical problems peculiar to the female, and the duty of each such officer shall be to advise with the head of his respective medical service (Army, Navy, or Air Corps) on the formulation of regulations, procedures, and practices affecting medical problems peculiar to women, and that a copy of this resolution be forwarded to the above named Senators and Congressmen.

Drs. Williams and Rawls said the Army and the Navy both have obstetricians and gynecologists in their service and Dr. Hodges felt they had as many as they needed. Dr. Knight moved the adoption of this resolution and it was seconded by Dr. Smith. Dr. Williams did not think the Society should take any action about the distribution of specialists in the army and navy and certainly not in isolated instances. The motion was lost.

The Cancer Committee had asked Dr. Powell if the Society would pay the expenses of Dr. Charles F. Branch inspector of cancer clinics in the United States for the American College of Surgeons, incident to attending their meeting to make a report which they had requested. Dr. Rawls moved that his expenses be paid. Seconded and carried.

It was stated that the Committee on Legislation had prepared a very complete pamphlet on chiropractors and naturopaths and wished instructions as to how this should be distributed. It was felt that the individual doctor should call this to the attention of the legislator and it should be sent the latter so he would have sufficient time to study it. Dr. Harrell moved that the pamphlets be distributed to the councilors and they in turn see that the family physician take it to the legislator. Seconded and carried.

Dr. Hamner presented the following resolution:

From reports of the press it is evident that there are certain factions in our government that are using the veterans of this war as political footballs and in so doing are placing a deep wedge for state medicine. The war has now been over for about two years. The government has recently turned over to the state the Woodrow Wilson Hospital and has closed one of the hospitals in the Newport News area. The Woodrow Wilson Hospital cost several million dollars to build. Recently from newspaper reports they purchased some ground in the Alexandria area for approximately $100,000 with the idea of constructing there a veterans hospital. If there is need for another veterans hospital in this area it seems rather poor business to give away one hospital and in approximately the same year make plans to build another hospital less than a hundred miles from the one that was given away.

We all agree that veterans that were wounded or became sick as a result of the war should receive the best attention possible, and there is no limit as to what should be done for them.

The question is why should the government now be planning to build many new veterans hospitals. There were more than ten million veterans in World War II. Take these veterans and the veterans of previous wars and you are taking from the practitioner (private) a large part of his income. The government is not giving to the veteran free coal, free housing and free clothing and it seems as if these are just as essential to the good living of the veteran as free medical care. As a matter of fact if all the plans now in contemplation go through it will make already scarce building materials much more difficult to procure with the result that those without homes will be much longer without them. It is also very probable that if the present plans go through that the veterans families will be next in line for free medical care. If 13,000,000 families are getting free medical care then you have state medicine.

The cost of building and equipment per hospital bed in a veterans hospital is approximately $20,000. The cost per day for a veteran in a veterans hospital is $18.00, whereas the cost for building and equipment in a civilian hospital is $10,000 and the per diem cost per patient in a civilian hospital the country over is from $10.00 to $12.00. Be It Resolved that this information be passed on to veterans organizations and that the American Medical Association be asked to oppose the construction of said veterans hospitals except as actually needed for the care of war wounded and sickness contracted as a direct result of the war.

The above has been presented and approved by the Prince Edward County Medical Society and the fourth District Medical Society.

Drs. Rawls, Robertson and Fisher did not feel the Council could do anything about this and they did not think it advisable to bring it to the House of Delegates.

The secretary was instructed to send a telegram to Dr. P. St. L. Moncure, one of the past presidents and a most active member, expressing the regret of the Council at his illness and hope for a speedy recovery.

There being no further business, the Council adjourned.

House of Delegates

The House of Delegates was called to order by the President at 11:00 A.M., October 13th at the Hotel Roanoke. Roll call showed a quorum present.

The minutes of the last meeting as published in the December 1946 issue of the MONTHLY were approved.

The budget, as approved by the Council, was then presented by Dr. Williams, chairman of the budget committee. It was moved and carried that this be accepted.

Committee reports as published in the October issue of the MONTHLY (pages 464-479) were considered as follows:

Executive Secretary-Treasurer (page 464)—accepted.

Director of Public Relations (pages 464-7)—accepted.

Delegates to the American Medical Association (page 467)—accepted.

Publication and Program (page 468)—accepted.

Clinical and Medical Education (pages 468-9)—accepted.

Scientific Exhibits and Clinics (page 469)—accepted.

Legislation (pages 469-70). Dr. Caudill, chairman, told of the pamphlet which had been prepared and published with regard to naturopaths and chiropractors. They will be distributed to the councilors and they in turn will see that the members get them. The individual member is to contact the representatives in the General Assembly. Dr. Hiden called attention to the article in *Hygeia* "Can Chiropractic Cure" and felt these could well be distributed to the county societies. The report was accepted.

Medical Economics (page 470)—accepted. Dr. Hundley, chairman, felt the committee had worked out of work because the legislation and public relations committees had taken over. He thought the question of continuing this committee should be discussed at the next meeting of the Council.

Ethics (page 470)—accepted.

Membership (pages 470-1). Dr. Harrell, chairman, read the recommendation with regard to the retiring president, Dr. Powell, being made an honorary member. Report accepted.

Judicial (page 471). Dr. Hutcheson, chairman, presented the following supplemental report:

Add to new Section 6 of Article VI: No Councilor who has served four (4) successive terms shall be eligible to succeed himself.

Article VIII, Section 1, add the following paragraph at end of section:

An executive committee of the Council composed of three members shall be appointed annually by the President. This committee shall act in an advisory capacity to the President in those matters in which the advice of the Council is desired, but which are not of sufficient importance to warrant calling a meeting of the full Council.

These, with the published report, were laid on the table for final action the next day.

Public Relations (pages 471-3)—accepted.

Rural Medical Service (pages 473-4). Dr. Mulholland, chairman, re-emphasized the importance of having these meetings with farmers and doctors and urged the members to attend and take part in the discussions. Report accepted.

Child Welfare (page 474). Dr. Gardner, chairman, stated that she hoped by next year to have some of these statistics published in the journal. Report accepted.

Maternal Health (pages 474-5)—accepted.

Walter Reed (page 475)—accepted.

To Confer with State Board of Nurse Examiners (page 475)—accepted.

Venereal Disease Control (pages 475-6). Dr. Butler, chairman, presented the following supplementary report:

1. To supplement the publicized report of the committee on therapy, it should be emphasized that the use of penicillin is still in the experimental stage, as far as the time and dosage factor is concerned.
2. To promote an educational program to the medical profession on the subject of the interpretation of serological results. Upon request the Venereal Disease Committee will supply competent speakers to appear before local medical societies.

The report and supplement were accepted.

Tuberculosis (pages 476-7). Dr. Harrell, chairman, moved that this be accepted and a copy sent to the Governor. In discussing this report, Dr. Roper stated that the Health Department, in a report to the Governor, had requested funds for a new 300-bed negro sanatorium in addition to 51 additional beds at Piedmont Sanatorium, for a new 100-bed infirmary at Catawba Sanatorium, and for 100 new beds at Blue Ridge Sanatorium—a total of 551 additional tuberculosis beds—and asked the support of the medical profession in this request. Report accepted.

Mental Hygiene (pages 477-8). Dr. Barrett said that any program of prevention in the field of mental health must be predicated on a program of sound physical health. He advocated a much more active treatment program at the hospital level and the development of an active program of out-patient mental hygiene clinics throughout the State, as this will cut down on the growing demand of hospital patients. The report was accepted.

Industrial Health (page 478). Dr. Stephenson, chairman, stated that he had learned the two medical schools are already having these courses on industrial health. Report accepted.

Cancer (page 478). Dr. Cooper, chairman, presented the following supplementary report:

Since the 1946 meeting of the Cancer Committee, Dr. Charles F. Branch, assistant director of the American College of Surgeons, has surveyed the tumor clinics and detection centers in Virginia. Dr. Branch attended the Cancer Committee's meeting last night and expressed full approval of the cancer program in this state.

Following his report, the Cancer Committee voted to approve the following clinics for the coming year:

The Elizabeth Buxton Tumor Clinic at Newport News
The Chesapeake and Ohio Tumor Clinic at Clifton Forge
The Dixie Hospital Tumor Clinic at Hampton
The Jefferson Hospital Tumor Clinic at Roanoke
The Lynchburg Tumor Clinic
The McIntire Tumor Clinic at the University of Virginia
The Medical College of Virginia Tumor Clinic at Richmond
The McCluer Diagnostic Tumor Clinic at Alexandria, and
The Diagnostic Tumor Clinic at Norfolk.

The Danville Tumor Clinic was given provisional approval subject to confirmation by the American College of Surgeons.

The Cancer Committee voted to recommend to the

Board of Trustees of the Virginia Division of the American Cancer Society that the Virginia Division reimburse the localities half of the money used by them for hospitalization of medically indigent cancer patients at the approved tumor clinic hospitals, provided the localities' funds are matched from the state hospitalization fund. The Cancer Committee also recommended that the Virginia Division pay x-ray therapy costs at the rate of $3.00 per treatment up to $25.00 for a course of treatments.

The Cancer Committee discussed the need for an organized speakers' bureau to supply speakers when requested for the component societies' programs and for post-graduate educational programs. It referred this question to the Committee on Post-graduate Medical Education, and will organize a speakers' bureau for cancer only if the Committee on Postgraduate Medical Education decides not to organize a bureau covering all fields of medical practice.

Dr. Mason Romaine, Director of the Bureau of Cancer Control of the State Health Department, presented his program for discussion. His initial projects are a central tumor registry, a program for professional and lay education, and a tumor tissue diagnostic service. His program was endorsed by the Cancer Committee.

Accepted.

Advisory to Woman's Auxiliary (page 478)—accepted. The following report was received from the Auxiliary:

TO THE HOUSE OF DELEGATES OF THE
MEDICAL SOCIETY OF VIRGINIA:

As president of the Woman's Auxiliary to the Medical Society of Virginia, I wish to submit the following report:

This year will complete our twenty-fifth year of service to the Medical Society of Virginia. Twenty-five years ago the Auxiliary was organized in Norfolk, and twenty-four years ago, the first annual meeting was held in Roanoke.

There are now 10 component auxiliaries with a paid-up membership as of October 1, 1947, of 409, showing an increase of 12 members for the year. There are 11 members-at-large and 2 honorary members. I regret to report a request of withdrawal received from the Auxiliary to the Loudoun-Fauquier Medical Society, which was granted.

Conditions made it impossible for me to accept invitations to visit the Auxiliaries and I could not attend the American Medical Association Auxiliary meeting in Atlantic City. However, I have enjoyed the personal contacts which have been gained through correspondence. Many letters have been received and I have written over five hundred during the year.

The Annual Conference for State Presidents and Presidents-elect held in Chicago in December was attended by the President and President-elect. The exchange of ideas at that conference was most beneficial, and I hope the conference will be continued.

The Virginia Auxiliary was ably represented at the Annual Meeting of the Auxiliary to the American Medical Association in Atlantic City last June and the reports of that meeting, by the delegates, encouraged and inspired us.

It was our pleasure to have as our guests at the Annual State Meeting at Virginia Beach, Mrs. Jesse D. Hamer, then President of the Woman's Auxiliary to the American Medical Association and Mrs. W. W. Potter, then President of the Auxiliary to the Southern Medical Association. Their messages were a challenge to greater endeavor and accomplishment.

One of the highlights of our year was the attendance of representatives of the Woman's Auxiliary, by special invitation from the Medical Society of Virginia, at the Five Point Public Relations Conference held at the John Marshall Hotel, Richmond on December 19, 1946. The discussions were informative, and very helpful to our Public Relations Chairman and our Program Chairman, both of whom were in attendance.

Our program for the year was planned to coordinate the objectives of the Auxiliary with those of the communities through more effective Public Relations. To the Public Relations meetings were invited representatives from all the women's civic organizations. Information was given on health education, legislation and the constructive medical service plans offered by the members of the medical profession, as an alternate to "Federalized Medicine".

The importance of the *Bulletin* has been stressed and we are glad to report an increase in the number of subscriptions, the total for the year being 85.

Hygeia is widely read and I feel that our subscription figure of 82 does not in any way reflect the extent to which this authentic health magazine is used.

Greater interest and activity have been shown in Cancer Control. Auxiliary members have served on the Board of the Virginia Cancer Foundation and done volunteer work in the Cancer Prevention Clinic and for Cancer Bandage Workrooms.

Virginia has participated in the three projects sponsored by the Woman's Auxiliary to the Southern Medical Association. More liberal contributions have been made to the Jane Todd Crawford Memorial Fund. Doctor's Day was observed in various ways with programs suited to the communities. There will be filed in the Southern Medical Lending Library an article written by one of our members on "The History and Romance of Medicine".

A particular project of the Virginia Auxiliary is the memorial fund established in memory of the Doctors Leigh, Hodges and Wright, to be used for a physician, or a physician's dependent, in a State Tuberculosis Sanatorium. This year the fund was used by a young physician. It is the hope that some day we will be able to accumulate a fund sufficient for the establishment of an endowment for a bed in one of our sanatoriums.

Through the courtesy of the Medical Society of Virginia, articles of interest and activities of the County Auxiliaries have been printed on the Auxiliary page of the MONTHLY.

The constitution, submitted by the Committee on Revisions of the Auxiliary to the American Medical Association, was accepted and our by-laws were revised to be consistent with those of the National Auxiliary and both were unanimously adopted at the Annual Meeting at Virginia Beach in 1946.

Our historian has carefully preserved all data received, but urges each County President to cooperate in assembling more information.

The Treasurer and Chairman of Finance have kept our finances in excellent condition.

Every member of the Auxiliary has been actively engaged in one or more phases of post-war work. The philanthropic work ranged from the donation of large sums to hospitals, a linen shower for a hospital, a scholarship for a nurse, library funds, Christmas parties and Christmas boxes for soldiers and crippled children, chaperoning U.S.O. parties, helping with Infantile Paralysis Drive, the establishment of a building fund to secure a home for the County Medical Society, the establishment of memorial funds for local hospitals to volunteer service in hospitals and clinics.

The social aspect of the Auxiliary has been more widely stressed this year. One Auxiliary gave an informal reception and a buffet supper for the doctors who were members of the County Medical Society and had as special guests the doctors and their wives who came to the County during the year. Another Auxiliary had a social affair and luncheon for the doctors in July at the beach. A dinner-dance was given by another to commemorate Doctor's Day.

To my official family, I wish to express my thanks for their unfailing kindness to me, for their loyalty, cooperation and able assistance on all occasions. Our associations

have been most pleasant. To the Advisory Council I express appreciation for their advice and encouragement. Thanks and appreciation are expressed to Miss Agnes V. Edwards, Executive Secretary of the Medical Society of Virginia, for her assistance. Gratefulness is extended for the generous assistance and interest which has been forthcoming at all times from Dr. W. L. Powell, President, and the other officials of the Medical Society. I bespeak for Mrs. McCormis the same consideration you have shown me.

In closing this report, I desire to express my gratitude to all members of this wonderful organization for the great privilege of serving as State President.

The Woman's Auxiliary may be very proud of the progress it has made in the first twenty-five years of organization. If the same degree of enthusiasm and sincere interest continues in the future, great hopes may be held for its development and its accomplishments, thus maintaining its high ideals of service.

Respectfully submitted

LOUISE J. HAMNER (Mrs. John Edward),
President, Woman's Auxiliary to the Medical Society of Virginia.

Rehabilitation (pages 478-9)—accepted.

Nutrition (page 479)—accepted.

National Emergency Medical Service (page 479)—accepted.

A recess was given for the appointment of a nominating committee, which resulted as follows:

1st District—Dr. E. B. Mewborne
2nd District—Dr. M. S. Fitchett
3rd District—Dr. Douglas Chapman
4th District—Dr J. L. Hamner
5th District—Dr. W. A. Porter
6th District—Dr. John Hundley
7th District—Dr. Alex Robertson
8th District—Dr. H. B. Mulholland
9th District—Dr. Frank Smith

A group life insurance plan had been offered members of the Society by the Connecticut General Life Insurance Company, and this was explained by Mr. G. H. Winfrey. The plan is voluntary but at least 75 per cent of the members and their employees must participate. The semi-annual rate for $1,000 will be approximately $9.00 and the amount a member may take varies with his age—less than 66 years of age, $7,500; 66 but less than 76 years of age, $5,000; and 76 years of age and over, $1,000. A general discussion brought out the following facts: this insurance may be paid to a beneficiary over a period of time or in a lump sum whichever is preferred; there is no cash value to the policy; if the plan goes through the detail work will have to be handled by the Society in the future; at least 75 per cent of employees of members must take the insurance. Dr. M. B. Hiden moved that the plan be accepted. This was seconded and carried.

Dr. Powell then announced that the House would have the privilege of hearing two speakers—one for the Association of American Physicians and Surgeons and the other for the National Physicians Committee. Dr. James King introduced Marjorie Shearon, Ph.D., Legislative Consultant of Washington, D. C., who spoke on Federal Propaganda for the Welfare States. Mr. M. H. Petersen, Chicago, then spoke on the National Physicians Committee.

Dr. W. B. Martin stated that he realized these talks would bring forth much discussion and resolutions and, due to the lateness of the hour, moved that resolutions be introduced at this time and action be deferred on them until the next meeting. Seconded and carried.

Dr. Ben Rawles, Jr., then read the following resolution:

WHEREAS, the Association of American Physicians and Surgeons has as one of its principal objects the maintenance of medicine as a free enterprise in the United States; and,

WHEREAS, the Association proposes to organize physicians to agree to participate only in such methods of rendering medical service which are in the public interest; and,

WHEREAS, the Association proposes to accomplish universal application of the insurance principle to the costs of medical care under proper voluntary plans; and,

WHEREAS, the Association proposes to educate the people to the use and benefits of voluntary plans of prepayment sickness insurance; and,

WHEREAS, the Association proposes to operate an endless public relations program which, first, will correct any errors within the profession, and then, use every available publicity channel to tell the public what has been accomplished in its interest; and,

WHEREAS, the Association proposes to conduct a continuing publicity campaign to inform all levels of the public of the value of the private practice of medicine and the evils of compulsory health insurance and state or socialized medicine; and,

WHEREAS, the Association proposes to earn again the respect for and understanding of the medical profession by the nation's lawmakers through proper, effective representation in Washington; and,

WHEREAS, the Association proposes to effect increasing support of the American Medical Association so that this scientific body may continue to improve upon its contributions to public health and the science of medicine;

NOW, THEREFORE, BE IT RESOLVED: That the House of Delegates of the Medical Society of Virginia does hereby approve the objectives of the Association of American Physicians and Surgeons.

Dr. Martin presented three resolutions as follows:

WHEREAS, competent nursing is an integral part of medical practice, and a proper concern of physicians and medical organizations; and

WHEREAS, the increasing shortage of nurses during recent years has now reached alarming proportions and seriously handicaps medical care; and

WHEREAS, at several sessions of the House of Delegates of the American Medical Association committees have been appointed to look into the matter, and at the last meeting in June, 1947, a committee of five (5) to be appointed by the president was authorized to study all aspects of the question; and

WHEREAS, the current system of training nurses is a principal cause of this shortage, and no relief may be expected until it is revised; and

WHEREAS, the curriculum which has been evolved during the past few decades and which is in operation at present has failed to produce better nurses. More and more time has been devoted to the study of supposedly ancillary subjects with the consequent neglect of training in the practical art of caring for the sick, with the result that the present-day graduate is not so well prepared to meet the patient's needs as were her sisters of a generation ago; and

WHEREAS, the present trend toward the formation of a new group of practical nurses is a significant develop-

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ment illustrating the need and demand for more effective nursing service.

THEREFORE, BE IT RESOLVED by the House of Delegates of the Medical Society of Virginia in session on October 14, 1947, at Roanoke, Virginia, that:

A proper integration of the training of the two groups of nurses should be effected in such a way as to best serve the purpose of good medicine, the welfare of the patient, the continued development of the nursing profession, and provide an adequate number of nurses trained in the art and practice of bedside nursing; and

BE IT FURTHER RESOLVED that this resolution be presented to the House of Delegates of the American Medical Association, and the copies be sent to the Special Committee on Nursing of the American Medical Association, the Nurses Association of Virginia, and the National Nurses Association.

WHEREAS: The business of this Society has become increasingly important and complexed;

WHEREAS: In the time available for full meetings of the House of Delegates it is impossible to give adequate consideration to important reports and resolutions;

THEREFORE, BE IT RESOLVED that the council be directed to consider the advisability of revising the procedure of the House of Delegates, and that they carry on the study either through their own body, or by a special committee appointed by the council.

BE IT FURTHER RESOLVED: That the council be empowered to set-up an improved procedure for the next meeting of the House of Delegates.

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1. WHEREAS, the most important problem before the medical profession today is, a better distribution of good medical care; and
2. WHEREAS, if the trend toward Federal Control of Medicine is to be permanently ended it must be done by an informed and aroused public; and
3. WHEREAS, an intelligent understanding of the problem of medical care by lay group would aid materially in accomplishing this purpose; and
4. WHEREAS, the spread of sound medical opinion as to the proper solution of the problem of medical care can be most effectively accomplished on the local level.

THEREFORE, BE IT RESOLVED, that the House of Delegates of this Society urge each county and component society to organize councils or committees on medical service made up of informed members of the profession, and representatives from important lay groups, and that these councils undertake the study of the medical problems in each community.

The House then adjourned to meet again the next afternoon at 4:30 P.M.

Second Meeting

The second meeting of the House of Delegates was held on October 14th at 4:30 P.M., with Dr. Powell presiding.

The first order of business was the report of the Nominating Committee, which was as follows:

President-elect—Dr. M. P. Rucker, Richmond

Vice-Presidents—Dr. Frank Farmer, Roanoke
Dr. W. D. Kendig, Kenbridge
Dr. P. W. Boyd, Winchester

Executive Secretary-Treasurer—Miss Agnes V. Edwards, Richmond

It was moved and carried that this be accepted.

Councilors from the odd numbered districts were named at this time:

1st—Dr. R. B. Bowles, Mathews
3rd—Dr. Guy W. Horsley, Richmond
5th—Dr. W. A. Porter, Hillsville
7th—Dr. R. P. Bell, Jr., Staunton
9th—Dr. James P. King, Radford

Dr. H. B. Mulholland, Charlottesville, and Dr. Walter B. Martin, Norfolk, were re-elected as delegate and alternate, respectively, to the American Medical Association for a term of two years.

An invitation was extended from the Richmond Academy of Medicine, the Richmond Chamber of Commerce, and Mayor Edwards of Richmond, to hold the 1948 meeting of the Society in that city. This was unanimously accepted.

The amendments to the By-Laws as presented at the first meeting of the House were next considered. It was moved and carried that these be accepted.

Dr. Hiden then offered a vote of thanks to the Roanoke Academy of Medicine and the Hotel Roanoke for their wonderful hospitality and the marvelous service they have rendered at this meeting. Carried.

Dr. K. D. Graves, secretary of the State Board of Medical Examiners, stated that the Board knows how many doctors have been licensed since 1885, but they have no way of knowing how many are in practice in Virginia at the present time. The Board felt there should be an annual registration of doctors in the State and he moved that the House go on record as approving this. Dr. W. B. Martin offered an amendment that the fee charged for this registration be only enough to defray the actual cost of operations. The motion was carried.

Dr. Martin's motions which were presented at the end of the first meeting were then considered. The first one, with regard to the education of nurses, was adopted, as was also the one with regard to the revision of the procedure of the House of Delegates. He moved the adoption of the resolution with regard to medical service and this was seconded. Dr. W. O. Bailey wanted to know how the doctors are going to get this information to give the public. Dr. Martin stated that the American Medical Association through its Councils on Medical Service and Rural Health has accumulated a lot of information. Mr. Johnson, Director of Public Relations of the State Society, should have this material available and should have it in the library of each hospital. The doctor can get the information but he must make it work because it is up to the individual doctor to arouse the public with regard to federalized medicine. Dr. H. B. Mulholland stated the Public Relations office had an exhibit at this meeting and they have a number of pamphlets on display which are available to doctors. The resolution was then adopted.

Dr. Kinloch Nelson asked if anyone knew whom to see about having the nursing education changed. Dr. Julian Rawls said that if a nurse graduated in less than three years she cannot get reciprocity in any of the northern states. Dr. Carrington Williams said he and Dr. Harry Warthen had looked up the law with regard to the nursing education and it states they should have two years of training. If a nurse is graduated in two years she will be a good clinical bedside nurse. If she wants to

be a specialist or have additional training, the hospital should provide post-graduate courses. Dr. J. M. Hutcheson said the object of this resolution was to record if possible the opinion of the medical profession with regard to the nursing situation. Such a record would be of service to the delegates in the House of Delegates of the American Medical Association. It was felt that as long as nursing is so closely allied to medicine, the doctor should have something to say about the necessary training.

Dr. B. F. Eckles, president of the State Board of Medical Examiners, stated that as long as Dr. Graves was not a delegate, he would like to offer the resolution with regard to registration of doctors, as presented by Dr. Graves, so as to legalize this. This was accepted.

Dr. Ben Rawles then presented his resolution, previously read at the first meeting, with regard to the American Association of Physicians and Surgeons. This was seconded. Dr. Martin thought this an extremely vital question that should be considered very carefully, as the medical profession is not in any too good grace now. Whenever a national organization goes before Congress they are assailed by the opponents as being opposed to any change favorable to the public. Another organization of doctors is not going to win the fight—it must be done on the local level. No organization of doctors is powerful enough to influence congressmen or legislators. The individual is the one who is going to inform them and having other people speak for them is a bad idea. Dr. M. B. Hiden stated this resolution asked for the endorsement of a group of principles all of which seem to be very good. Man's own conscience guides him as to whether certain practices are good or bad for the public. It is only stated that if the government puts out a program which is detrimental to the people, the members will not cooperate with it. It is not drawing the doctor into something that he cannot get out of. Dr. Martin stated that one of the principles of the AAPS is that the medical profession will withhold medical care under certain conditions. Dr. J. P. King stated that it was never their intention to strike against the American public but a desperate battle is being fought to preserve what the doctor now has. Dr. A. M. Showalter said that his society the Southwestern Virginia, had endorsed the AAPS and the delegates had been instructed to vote for this resolution. He felt the doctors had objected to a good many things in the past—public relations, the NPC, etc.—but in the long end they had gotten much out of them. Dr. Hiden stated that Dr. Martin objected to the statement that doctors will not cooperate with a system which they think detrimental to their patients and asked if *he* expected to cooperate with a system which he thought detrimental to his patients. Dr. H. H. Hurt said that of course doctors are not going to do anything harmful to their patients but they certainly did not want to do anything detrimental to the practice of medicine. He felt if this resolution were passed, organized labor would turn against the medical profession. Dr. J. W. Love stated that his organization did not instruct their delegates how to vote but expected them to vote for themselves and he was not in favor of endorsing this resolution. Dr. Mulholland said that everything in this resolution was in the platform of the American Medical Association except for the non-participation clause. One of the greatest criticisms the medical profession has gotten is that they do everything in a negative way and this is surely negative action. Dr. J. L. Rawls did not feel anything could be gained except direct antagonism.

A vote being taken the motion was lost.

Dr. Ben Rawles stated he felt Dr. Martin's resolution with regard to medical service called for renewed activities and it is up to the doctor to go back home and do something about it and not just sit down and do nothing. The doctors should do everything possible to help carry out the program of the American Medical Association.

Dr. N. F. Rodman moved that the Society appoint a committee of at least one man from each congressional district to cooperate with the National Physicians Committee. He felt the man of the street, the laborer, and the man of the union should be told what they will get with socialized medicine. He did not think most of them realized they would have to pay for it. The motion was seconded. Dr. Julian Rawls explained some of the workings of the NPC. Dr. W. R. Pretlow thought the only solution to the problem was for the doctors to offer a good substitute for state medicine—give the people something in place of what you are opposing. The motion, being put to vote, was lost.

Dr. Joseph S. Lawrence, Washington representative of the Council on Medical Service of the American Medical Association, was present and was extended the privilege of the floor. He stated that the medical profession is still in a position where it should be exerting itself in familiarizing local representatives with their attitude on socialized medicine. This can be constructive and does not have to be destructive. He did not think the Wagner-Murray-Dingell Bill would get before the House now but something else will come up in its place. The public had been led to believe that medical science has developed far beyond its application to the individual. A few years ago a person did not call the doctor unless he had an emergency but today the people want to take advantage of medical care. They feel they will have medical care if they subscribe to this medical bill. It is up to the doctors to educate them.

There being no further business, the House adjourned.

AGNES V. EDWARDS,
Secretary.

Approved:
W. L. POWELL, *President.*

Auditor's Report

October 1, 1946—September 30, 1947

THE OFFICERS AND COUNCILORS,
MEDICAL SOCIETY OF VIRGINIA,
RICHMOND, VIRGINIA.

GENTLEMEN:

We have made an examination of the books of the Medical Society of Virginia for the fiscal year ended

September 30, 1947, and have prepared the two accompanying statements. The scope of our examination is explained in the following comments.

The assets and liabilities of the Society at September 30, 1947, are stated in the Balance Sheet, Exhibit "A", the Income and Expenses for the fiscal year ended at that date, on the cash receipts and disbursements basis, are shown in Exhibit "B", and receipts and disbursements of the Legislative Committee Special Fund as Exhibit "C".

Yours very truly,

MITCHELL, WIGGINS & SMITH,
By R. E. WIGGINS,
Certified Public Accountant.

Financial Condition

The financial condition of the Society at September 30, 1947, is given in the Balance Sheet, Exhibit "A", a summary of which is supplied below in comparison with that at September 30, 1946:

ASSETS	9-30-47	9-30-46
Cash	$36,756.49	$21,403.44
Accounts Receivable	1,994.88	1,365.86
Investments—U. S. Bonds	31,649.50	31,211.50
TOTAL	$70,400.87	$53.980.80
LIABILITIES AND SURPLUS		
Liabilities:		
Accounts payable	$ 857.00	$ 1,063.16
Surplus:		
General Fund	55,074.31	38,329.26
Special Legislative Fund	14,469.56	14,588.38
TOTAL	$70,400.87	$53,980.80

Operations

The income and expenses of the General Fund for the fiscal year ended September 30, 1947, are shown in Exhibit "B", prepared on the cash receipts and disbursements basis. A condensed statement of these, in comparison with the results for the preceding year, shows:

INCOME	9-30-47	9-30-46
Membership Dues	$36,327.35	$ 8,789.83
Medical Monthly Publication	17,656.25	15,870.31
Miscellaneous	637.34	2,206.70
TOTAL	$54,620.94	$26,866.84
EXPENSES		
Executive Office	$21,673.77	$19,796.30
Public Relations Department	17,407.80	5,633.50
TOTAL	$39,081.57	$25,429.80
SURPLUS INCOME FOR THE YEAR	$15,539.37	$ 1,437.04

The receipts and disbursements of the Legislative Committee Special Fund are stated in Exhibit "C".

Scope of Examination

All recorded receipts were accounted for by bank deposits, and disbursements were supported by properly signed and endorsed paid checks. Balances on deposit at September 30, 1947, were confirmed by statements on file from depositories as follows:

GENERAL FUND	
First and Merchants National Bank—Checking Account	$19,303.55
First and Merchants National Bank—Savings Account	5,393.90
The Bank of Virginia—Savings Account	6,705.09
Southern Bank and Trust Company—Savings Account	941.89
TOTAL	$32,344.43
LEGISLATIVE COMMITTEE--SPECIAL FUND	
First and Merchants National Bank—Savings Account	$ 4,412.06

Investments, consisting of United States Savings Bonds, were verified by inspection of the bonds on hand. These are shown at their current redemption value on the balance sheet.

Insurance in force, determined from policies on file, was as listed below:

Office Furniture and Fixtures	$1,000.00
Walter Reed House, Belroi, Virginia	1,000.00
Fidelity Bond, Secretary-Treasurer	2,500.00

Balance Sheet—September 30, 1947
Exhibit "A"

ASSETS

CASH		
General Fund	$32,344.43	
Special Fund — Legislative Committee	4,412.06	$36,756.49
DUE FROM MEMBERS (Estimated Collectible Value):		
1947 Dues—30 @ $25.00		750.00
ACCOUNTS RECEIVABLE		
Virginia Medical Monthly for Advertising		1,244.88
INVESTMENTS		
United States Savings Bonds:		
General Fund	$21,592.00	
Special Fund—Legislative Committee	10,057.50	31,649.50
		$70,400.87

LIABILITIES AND SURPLUS

LIABILITIES		
Accounts Payable:		
Preparation of Medical Journal—September, 1947, Issue	$ 802.00	
Social Security Tax	55.00	$ 857.00
SURPLUS		
General Fund	$55,074.31	
Special Fund—Legislative Committee	14,469.56	69,543.87
		$70,400.87

Statement of Income and Expense

For Fiscal Year Ended September 30, 1947

Exhibit "B"

GROSS INCOME	ACTUAL	BUDGET
Membership Dues	$36,327.35	
Commercial Exhibits — Net Receipts	497.19	
Royalties on History of Medicine	62.20	
Interest on Savings Accounts	77.95	
Virginia Medical Monthly:		
Advertising	17,257.15	
Subscriptions from Non-Members	399.10	
TOTAL GROSS INCOME	$54,620.94	
EXPENSES		
Executive Office:		
Salaries	$ 6,400.00	$ 6,400.00
Bonuses for Year Ended September 30, 1946	600.00	600.00
Office Rent	600.00	600.00
Telephone and Telegrams	175.53	150.00
Stationery and Office Supplies	156.54	110.00
Repairs and Replacements	121.76	150.00
Postage	288.82	275.00
Audit Fee	85.00	90.00
Social Security Tax	49.49	60.00
State Convention Expense—1946	1,038.22	700.00
Delegates to A. M. A. Convention	309.24	309.24
Councilor's and Secretary's Expense	74.70	100.00
President's Expense	100.00	100.00
President-Elect's Expense	-----	50.00
Walter Reed Commission Expense	66.00	125.00
Special Appropriations by Council and President	337.39	337.39
Preparation and Distribution of Medical Journal	10,321.84	10,000.00
Miscellaneous Expense	41.80	75.00
Committee Expenses:		
Clinical and Medical Education	316.24	1,200.00
Maternal Health	13.50	20.00
Cancer Control	121.57	145.00
Scientific Exhibits	456.13	456.13
Public Relations and Medical Service	-----	300.00
Child Welfare	-----	10.00
Industrial Health	-----	20.00
TOTAL—EXECUTIVE OFFICE	$21,673.77	$22,382.76
Public Relations Department:		
Salary—Director	$ 7,000.00	$ 7,000.00
Salaries—Secretarial	1,762.55	2,000.00
Traveling Expense	1,171.97	2,000.00
Conferences	266.50	1,000.00
Radio Programs	2,739.82	3,500.00
Press—Advice, Space, Etc.	1,333.08	6,000.00
Printing, Literature, and Bulletins	119.14	3,000.00
Telephone and Telegrams	569.85	1,000.00
Office Rent	565.00	600.00
Stationery and Office Supplies	391.43	500.00
Postage	360.06	700.00
Office Equipment	1,072.01	1,000.00
Miscellaneous	56.39	1,300.00
TOTAL—PUBLIC RELATIONS DEPARTMENT	$17,407.80	$29,600.00
TOTAL EXPENSES	$39,081.57	$51,982.76
SURPLUS INCOME FOR THE YEAR	$15,539.37	

Legislative Committee Special Fund Receipts and Disbursements

For Fiscal Year Ended September 30, 1947

Exhibit "C"

BALANCE—October 1, 1946		$ 4,598.38
RECEIPTS		
Membership Dues @ $2.00 Each	$ 278.00	
Interest on Savings Account	35.68	313.68
TOTAL AVAILABLE		$ 4,912.06
DISBURSEMENTS		
Legal Service		500.00
BALANCE—September 30, 1947		$ 4,412.06

BOOK ANNOUNCEMENTS

Concise Anatomy. By LINDEN F. EDWARDS Ph.D., Professor of Anatomy, The Ohio State University, Columbus, Ohio. The Blakiston Company, Philadelphia and Toronto. xxiv-548 pages. Cloth. 324 illustrations.

Concise Anatomy supplants the former text "Anatomy for Physical Medicine". The purpose of this text is to supply a useful book to students in ancillary fields to medicine, such as Physical Therapy, Occupational Therapy, Medical Technology, Nursing, Dental Hygiene, Physical Education, etc. The order of presentation of the original text has been retained. New textual material and illustrations have been added and various parts have been rewritten. Emphasis is laid on microscopic, developmental and functional significance of structure. This method of presentation greatly facilitates anatomical thinking and creates in the beginner an interest in living anatomy.

It is perhaps regrettable that all color plates of the original text have been omitted, which so greatly aid the beginning student in visualizing structures. However, the text is highly readable and if its purpose is to supply a useful book to students who have a limited time to study anatomy at their disposal, it succeeds admirably.

SUSANNE HIRT

New and Nonofficial Remedies, 1947. Containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1947. Cloth. Price, postpaid, $3.00. pp. 749 Philadelphia: J. B. Lippincott Co., 1947.

Although the latest edition of New and Nonofficial Remedies has some eleven pages fewer than the 1946 book, its increase in size, due to the heavier paper used, and its change of color— dark green to bright red—combine to make a striking contrast with the earlier annual volumes. Another innovation is the relegation of the statements of tests and standards to the back of the book, which makes the text more convenient and usable.

There appears to be no very extensive revision in the various general articles or chapter head discussions, although several new monographs have made their appearance and others have been revised to reflect current medical opinion.

New and Nonofficial Remedies remains a most valuable and authoritative compendium of modern rational therapeutics. With successive editions, it becomes more useful and accessible to the physician and to all those interested in the use, preparation, or manufacture of drugs.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1946. Cloth. Price, postpaid, $1.00. pp. 135 Chicago: American Medical Association, 1947.

This volume was formerly of most interest to those who wished to know why the Council on Pharmacy and Chemistry had not accepted certain of the preparations it had considered. The reports were mainly those of rejection; though, through the years, the educational nature of the Council's work was attested by status reports on drugs, or therapeutic procedures, or preliminary reports on agents showing promise of usefulness but not yet ready for adoption by the general and medical profession. In recent years, the tendency has been toward a preponderance of the educational type of report. In the present volume, both the condemnatory and the educational phases of the Council's work are represented.

Among the status reports, the excellent article of Dr. Samuel M. Feinberg, "Histamine and Antihistaminic Agents", is probably most worthy of mention. Since its appearance, the Council has accepted for inclusion in New and Nonofficial Remedies, the two new agents of this class evaluated in the article, Diphenhydramine Hydrochloride, and Tripelennamine Hydrochloride (Benadryl Hydrochloride and Pyribenzamine Hydrochloride, respectively).

Attention is called to the several reports on the adoption of generic designations for drugs proposed or marketed under protected names. Not all such actions of the Council have been the subject of separate published reports; the recognized terms have appeared in the published descriptions of the drugs when accepted, and will be inserted in another Council publication, New and Nonofficial Remedies, as adoption of such designations for already accepted protected names proceeds.

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EDITORIAL

Virginia and the Hill-Burton Bill

NOW is the time for all county medical societies to become active. The doctors of the country are to be provided with places in which to work. It is up to them to determine what these places shall be. Under the provisions of the bill the Federal Government will furnish one-third of the cost of construction and the community has to furnish two-thirds of the construction costs and provide for the upkeep. The bigger the facility the more federal money, but the citizens will have to go down in their pockets much deeper. There is always a practical mean between what is necessary and what is desired, and this happy mean is determined largely by what can be afforded. This is something that each community must decide for itself. The doctor is interested on two counts: (1) as a prospective user and (2) as a citizen who will have to pay for it. Therefore, he should take the lead in making a survey of the local medical need, but he will have to have the help of the whole community. We suggest the formation of local health councils composed of all organized groups. Farmers, labor, business and the professions should work together on such councils.

The first step in the utilization of Hill-Burton funds is a state-wide survey of the existing hospital facilities and the health needs. This has been done and the report is in the hands of Governor Tuck. We have not seen the report, but we have heard Mr. A. Gibson Howell, who made the survey, explain it. County lines and political bounds have been disregarded. Trade centers have been plotted on the map of the State and it is recommended that hospitals be built in these places. The size of the hospital is determined by the number of persons the trade center serves; a forty bed hospital here, a sixty bed hospital there, and a ninety bed hospital yonder. The largest hospitals of course are to be in the larger cities, and the capstones of the system are to be connected with the two medical schools. In the smallest communities there are to be health centers suitable for the treatment of accidents and emergencies. These should be so located that the services of the local health nurse would be available, and their supervision could be a duty of the local health officer. The minimum equipment should be sufficient to treat shock—intravenous sets, plasma and a connection with a blood bank that would provide blood without delay. It would be likely that such a facility would be a center for the local medical, dental and nursing professions. A laboratory and a technician would be provided in many of these centers. Even a reading room and library might be possible. The proposed set up is quite similar to that used in the army in the last war; general hospital, station hospital, field hospital, portable hospital and collecting station.

The health center or dressing station should meet with almost universal approval. It would cost comparatively little and its maintenance could be underwritten by a service club or some similar group. The small hospital is quite another matter. In a recent hospital survey in Richmond by a recognized authority, the statement was made that a five hundred bed hospital was the most economical size. Such a hospital could provide services (that of a full time pathologist to mention one) that smaller hospitals could neither afford nor obtain. It is well known that hospitals of less than one hundred beds have great difficulty in getting interns. Might it not be better to concentrate hospital facilities into larger units, especially since provision is to be made for the treatment of emergencies on the spot? If a patient who is not in shock could be gotten to a one hundred and twenty or one hundred and fifty bed hospital within an hour, he would fare better than he would in a forty bed hos-

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pital only ten minutes away. The cost of maintenence of a hundred and twenty bed hospital would be less than three forty bed hospitals. The State has already solved a similar problem in education except that the building and staffing of a school is simple in comparison with a hospital. At first a one room school house was built in walking distance of every child. Such a plan proved both inefficient and expensive. Now we have centrally located modern schools for a whole county and the children are brought to them in buses.

The question of how big to build the proposed hospitals and where to locate them so as to serve the people best requires careful study. It cannot be decided off hand and it must be decided at the local level. That is why the county medical societies are so important at this time.

Nazi Doctors

SEVEN of the 23 Nazi doctors who were indicted for crimes against humanity were condemned to be hanged and many of the others received long time sentences. This is the first time in history that a doctor of medicine has been so much as even accused of such heinous crimes. It was said these mass sadistic experiments were carried out in the interest of science. The only thing that was learned, was that a half frozen soldier responded more rapidly to the heat supplied by a naked maiden in bed with him, than to any other form of heat. A list of the experiments reminds one of the days of the Inquisition except that in the Inquisition the tortures were directed by Priests upon individuals in an effort to save their souls. The Nazi tortures were done in a wholesale manner with not the least excuse. In Nero's time Christians were put to death in a similar wholesale manner, for the amusement of the populace. There seemed to have been little if any sadist element.

When medicine was young in Babylon, a physician sometimes had his hands cut off when he inadvertently caused the death of a patient or the loss of an eye. This was just a way the Babylonians had of making the doctor careful. In the middle ages some doctors were burned at the stake—Michael Servetus for instance, suffered in this manner but not for any medical practices. He and his books were burned because he had a different idea of the Trinity than the current ones. A Dr. Wertt of Hamburg was burned at the stake in 1522 because he impersonated a woman in order to gain admission into a lying-in room and observe the process of a normal birth. This might be called a crime against decency but it certainly was not a crime against humanity. Coming down to modern times Dr. Samuel Mudd was imprisoned for life in a tropical fortress because he treated the broken leg of a stranger who turned out to be Wilkes Booth, Lincoln's assassin.

Until now no doctor of medicine has been tried, much less convicted, for a crime against humanity. There must be something in the medical discipline that accounts for such a record. Other men, preachers, lawyers, politicians and business men may be more learned and even wiser, but it is the character of the physician that makes him what Stevenson calls the flower of our civilization. The important thing then, now that the fact has been thus definitely established, is why this thing could happen. Had training in medicine deteriorated so much in Germany, that its humanizing influence could no longer withstand the inhuman philosophy of the Nazis. It is well known that the teaching of medicine in Germany under political management had fallen from world leadership. Just how much, under Nazi domination it had deteriorated, is not known. The reports about the treatment of prisoners by German

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Army surgeons vary as one would naturally expect, but most of the reports were that the German Army surgeon was skilful and humane even if not sympathetic. Perhaps the doctors who were intrusted with these inhuman experiments were especially trained in the inner Nazi circles. It would be extremely interesting to know what the rank and file of the German physicians think of such practices. If the crimes of the Nazi doctors are condoned by the average German physician, some radical changes in the German medical curriculum must be made.

Experiments upon Human Beings

SO long as there is an abundance of fruit flies, African toads, mice, rats, guinea pigs, rabbits, pigeons, cats, dogs, horses and monkeys available, and so long as antivivisectionists do not forbid their use, there is no need of using man for experimental purposes, except in very rare instances. These occasions have arisen in connection with diseases peculiar to man. Until the Nazis upset all precedents of decency, experiments upon human beings have been few, and the experimentees have not been allowed to volunteer until after the risks that they ran have been fully explained to them.

When Jane Todd Crawford presented herself to Ephraim McDowell with a huge ovarian tumor, her condition was considered hopeless. No such tumor had ever been removed; in fact few abdominal operations of any kind had been successful. McDowell told Mrs. Crawford that her only hope was in extirpation of the tumor, and that it was merely an experiment. She said that she was willing to go through with the experiment. Mind you, that was before the days of anesthesia. She went through with it in a way entirely in character with the heroine that she was. Thus was laid the foundation for abdominal surgery. In a similar way little Joseph Meister the first person whom Pasteur treated for rabies, has gone down in medical history. Crawford W. Long's patient, James Venable, the first person ever to undergo ether anesthesia, and Gilbert Abbott, Warren's patient, to whom Morton gave ether without knowledge that it had ever been done before, merit our praise and thanks. Long's wife, the first woman to undergo obstetric anesthesia (Dec. 17, 1845), belongs in the same category.

In a somewhat different category are the medical men who deliberately experimented upon themselves in order to establish medical truth. One of the earliest of these was the celebrated John Hunter, who in the course of his studies of venereal disease in 1767, inoculated himself with gonorrheal pus in order to prove that gonorrhoea and syphilis were not the same disease. Unfortunately for Hunter and medical science the patient had a mixed infection. Hunter contracted syphilis and the two diseases were considered different manifestations of the same disease until Philippe Ricord (1799-1889) years later proved that Hunter was wrong. A more formidable experiment was undertaken in 1885, when Daniel A. Carrion, a Peruvian medical student, undertook to prove the relationship between Oroya fever and *verruga peruana*. He inoculated himself with blood and tissue from a verruga nodule, and nine days later died of typical Oroya fever. The self-martyrdom of Howard Taylor Ricketts in Mexico City (1910) in connection with typhus fever is better known in the United States.

The introduction of anesthesia was the occasion of much human experimentation. In addition to (1) the "first" patients mentioned above, there were (2) a number of medical men who experimented upon themselves. Horace Wells, a dentist of Hart-

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ford, had himself anesthesized with nitrous oxide in order to test its effectiveness. Later in Edinburgh, Sir James Y. Simpson, George Keith and Matthews Duncan put themselves to sleep with chloroform in their experiments to find a substitute for ether.

However, the search for the cause of yellow fever was the occasion for the most extensive human experimentation. The entire Yellow Fever Commission of the United States Army experimented upon themselves and Carroll and Lazear came down with the disease. Lazear's case was fatal. In addition there were a number of volunteers from the enlisted men for the elaborate experiments to prove that the Stegomyia fasciata was the vector and the only vector of the dread disease.

This brings us to the third category. We have already discussed "first" patients who might expect personal benefit should the "experiment" prove successful, and second the medical men who were driven by scientific curiosity. The third group had only altruistic and humanitarian motives. In this group belongs James Phipps, who in 1796 was inoculated by Jenner with cow pox and later submitted to an inoculation with smallpox to test the effectiveness of vaccination. However, the first prize in heroism belongs to the United States soldiers who voluntarily submitted to the conditions of Camp Lazear. They were isolated from their fellows, exposed to infected mosquitos and shut up in a small illy ventilated building containing dreadfully contaminated, soiled garments of yellow fever patients. They even slept in clothes in which yellow fever patients had died. John R. Kissinger and John J. Moran submitted to the bites of the mosquitos and both contracted the disease. Folk, Jernigan and Dr. Robert P. Cooke slept with the fomites and were unharmed. In the opinion of Major Walter Reed, this exhibition of moral courage has never been surpassed in the annals of the Army of the United States.

The General Practitioner and the Tumor Clinic.

AT the last meeting of the Medical Society of Virginia, the attention of the cancer Committee of the Society was called to the fact that physicians interested in cancer control but residing in localities unable to staff a Tumor Clinic feel left out of the cancer program.

The ultimate unit in a cancer control program is the individual physician. How successfully cancer is controlled in any state depends on how high a percentage of doctor's offices serve as cancer detection centers, on how many physicians are on the alert for cancer.

The function of the Cancer Committee is to stimulate "cancer consciousness" among physicians. Its purpose in certificating Tumor Clinics is to provide information to State and volunteer agencies as to where public monies can be effectively spent for the handling of medically indigent proven or suspected cancer patients. The Cancer Committee hopes and believes that the work done in the Tumor Clinics not only services the indigent sick but stimulates awareness of the cancer problem among physicians. The fact that some doctors residing in localities unable to organize a Tumor Clinic feel left out of the cancer program supports that belief.

But it is not necessary to serve on a certificated Tumor Clinic staff to participate in cancer control. It is far more important for each doctor to see to it that, in so far as possible, cancer among his patients is prevented and diagnosed early. To those interested in a group effort, the Cancer Committee calls attention to the possibilities offered by Diagnostic Follow-Up Tumor Clinics. Every county and locality can staff such a clinic where medically indigent cancer suspects may be investigated. Proven

cases, upon completion of this work-up and such surgical treatment as may be possible locally, can be referred to the nearest certificated Tumor Clinic for x-ray therapy. In a locality which does not have full surgical facilities, cancer suspects can be investigated in a Diagnostic Tumor Clinic and referred to a larger center for surgery as well as x-ray therapy. The Cancer Committee feels that "full surgical facilities" implies not only adequate hospital and operating room equipment but also the services of a surgeon with adequate training and experience in cancer surgery. Regardless of the manner in which the case is handled, the patient, on completing his treatment, will be followed up at stated intervals in the Diagnostic-Follow-Up Clinic. The Cancer Committee invites formation of Diagnostic Tumor Clinics and will welcome inquiries from interested groups.

GEORGE COOPER, JR., M. D.,
Chairman, Cancer Committee,
Medical Society of Virginia

SOCIETIES

The Mid-Tidewater Medical Society

Met at West Point on October 28th, with Dr. W. H. Springall presiding. The following program was presented: Disease of the Rectum by Dr. Russell Buxton; Delivery of Retained Placenta by Dr. C. D. Bradley; and Arthritis by Dr. William Read. All speakers are of Newport News.

Officers for 1948 were named as follows: Dr. J. R. Gill, Mathews, will succeed to the presidency; Dr. M. H. Harris, West Point, president-elect; Drs. J. M. Gouldin, Tappahannock; A. L. VanName, Urbanna; H. A. Tabb, Gloucester; R. B. Bowles, Mathews; R. D. Bates, Newtown; Clarence Campbell, Sparta; A. W. Lewis, Jr., Aylett; and J. R. Parker, Providence Forge, vice-presidents; and Dr. W. H. Hosfield, West Point, secretary-treasurer.

Northern Neck Medical Society.

The October meeting of this Society was held on the 23rd at The Tides Inn, Irvington, with the president, Dr. C. Y. Griffith, Machodoc, presiding. The following officers were elected: President, Dr. A. Broaddus Gravatt, Jr., Kilmarnock; vice-presidents, Dr. H. E. Sisson, Warsaw, and Dr. M. Mercer Neale, Jr., Heathsville; and secretary-treasurer, Dr. Lee S. Liggan, Irvington (re-elected).

Alexandria Medical Society.

This Society was addressed by Dr. G. Halsey Hunt of the U. S. Public Health Service at its meeting on November 13. He had recently finished a study of group practice and presented a resume of his findings. He discussed the physical make-up of group practice, the various financial arrangements, the types of groups, and the role of the general practitioner in group practice. The presentation was well organized, thorough and enlightening.

GEORGE SPECK,
Secretary.

The Wise County Medical Society

Met at Hotel Norton the evening of November 12, 1947 as the guests of Dr. A. H. Bond of Norton, who served the steak dinner with all the attachments that go with it. This was an outstanding meeting with twenty-seven in attendance.

Dr. John R. Daugherty of Knoxville, Tennessee, gave a lecture on "Urological Problems", which he illustrated with a hundred x-ray films selected from his records.

Dr. Eugene J. Yorkoff of Pound and Dr. G. F. Sutherland of Big Stone Gap were elected to membership.

At the close of the meeting there was a film in color on the "Treatment of Anemia".

T. J. TUDOR, *Secretary*

Roanoke Academy of Medicine.

At the November meeting of the Academy, held on the 3rd, the following scientific program was presented: The Modern Treatment of Syphilis and Gonorrhea by Dr. John F. Mahoney, Medical Director of the U. S. Public Health Center at Staten Island; and Recent Advances in Chemotherapy of

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Tuberculosis by Dr. H. H. McLeod Riggins, President, Trudeau Society, New York City.

Dr. Charles M. Irvin is president of the Academy and Dr. Ira Hurt, secretary-treasurer.

Lynchburg Academy of Medicine.

The regular monthly meeting of the Academy was held on October 20th. The speaker for the evening was Dr. Frank Lock, Professor of Obstetrics and Gynecology at the Bowman Gray School of Medicine, Winston Salem, North Carolina, who spoke on "Psychomatic Gynecologic Problems".

The Virginia Peninsula Academy of Medicine

Had as its November speaker Col. James P. Cooney, M. C., of Washington, D. C., who discussed the effects of the atom bomb, he having participated in the Bikini experiment. The meeting was held in the Officers' Club at Langley Field and there was an attendance of 110. Col. Cooney came upon the invitation of Col. Gus Ledfors, M.C., commanding officer of Langley Field Hospital. Dr. Paul Hogg of Newport News presided and Dr. Chester D. Bradley of Newport News was at the secretary's desk.

NEWS

The Southern Medical Association

Is holding its annual meeting in Baltimore, November 24, 25 and 26, under the presidency of Dr. Elmer L. Henderson of Louisville, Ky. There will be scientific and technical exhibits, general meetings and scientific sessions as well as gatherings of allied associations. Social features will also add to the interest and pleasure of those attending.

Dr. Rudd Honored.

A portrait of Dr. Wortley F. Rudd, former dean of the School of Pharmacy, Medical College of Virginia, was presented to the College by the Richmond Retail Druggists Association in the auditorium of the Richmond Academy of Medicine on November 7th. The portrait was painted by John D. Slavin of Richmond.

W. E. Locke, a past president of the association, presented the portrait to the Medical College, and it was accepted for the college by Robert T. Barton, Jr., vice-chairman of the Board of Visitors. Senator Lloyd C. Byrd spoke on "Dr. Rudd as a Teacher", and Dr. John Bell Williams eulogized him as a friend.

Dr. Rudd retired July 1st after serving twenty-seven years as dean of the School of Pharmacy of the Medical College of Virginia and 43 years as a member of the faculty.

Dr. Melvin W. Lamberth, Jr.,

Recently of Richmond, is now located for general practice at Kilmarnock.

Christmas Seals.

The Christmas Seal Sale is already under way. Much excellent work is accomplished with the money received from their purchase and this is to urge our readers to help again this year as they have in the past.

Corrective Physical Rehabilitation.

Latest developments in the field of corrective physical rehabilitation were presented during a school for corrective therapists from Veterans Administration Hospitals in nine States held at McGuire VA Hospital in Richmond from November 10 through 22.

Among those on the school program were Dr. Edmund M. Ellerson, McGuire manager; Dr. George T. Stafford, health coordinator of the University of Illinois and a VA consultant; Dr. John Eisle Davis, the VA's chief of corrective physical therapy; Dr. George G. Deaver, physician in charge of rehabilitation and physical medicine, New York University Medical College and Bellevue Hospital; Kjell Peterson, athletic director of Metropolitan Life Insurance Company and a VA consultant; Dr. A. B. C. Knudson, assistant VA chief of physical medicine; and Dr. A. Ray Dawson, who became chief of the VA's physical medicine rehabilitation service on November 15 after serving for a year and a half as rehabilitation chief in the VA Richmond Branch Office.

Those from the Medical College scheduled to

take part in the school included Dr. Josephine Buchanan, Dr. Ellen N. Duvall, Dr. Ernst Fischer, Dr. F. A. Hellebrandt, Susanne Hirt, Sarah J. Houtz, Helen V. Skowlund, Dr. Elam C. Toone, Jr., and Edith Vail.

Among those representing McGuire were Dr. Benedict Nagler, Dr. G. S. Maxwell, Dr. H. S. Talbot, Dr. J. E. Hopkins, Dr. J. L. Ulmer, Dr. Jerome Lee, and Leon Edman. Raymond W. Swanson, executive officer of the branch rehabilitation division, also took part in the school.

Medical College of Virginia.

Despite shortages of personnel and difficulties in obtaining supplies the Medical College of Virginia Hospital last year cared for the largest number of patients in its history, Mr. C. P. Cardwell, Jr., Director, stated. Hospital admissions had steadily increased from 7,906 in 1928-29 at the rate of about 1,000 a year until 1937-38 when they climbed about 2,000 a year reaching a peak last year with 18,701.

Surgical operations numbered 3,547 nineteen years ago and remained under 4,000 until 1932-33 when they increased very rapidly to an all time high last year with 7,515 recorded in the nine operating rooms of the hospital.

While according to Mr. Cardwell there has been a decline in home obstetrical deliveries by members of the hospital staff, he said there has been a marked increase in the number of obstetrical deliveries within the hospital during the past nineteen years. In 1929-30, for instance, 330 deliveries were made within the hospital and 298 in homes whereas last year 3,080 deliveries were made in the hospital and 191 in homes.

During the nineteen year period from 1928-29 to 1946-47 the greatest increase in service was reported to be in the emergency room where in 1928-29 there were 3,064 patients treated as compared with 30,258 last year. Trailing closely, however, was the growth in the pharmacy department of the hospital where in 1928-29 19,326 prescriptions were filled as compared with 117,358 last year. The hospital director pointed out that in the nineteen year period visits to the out-patient clinic had increased from 34,609 to 72,963, visits to the dental clinic from 10,000 to 23,110, and hospital dental cases from 2,411 to 5,426.

The house staff of the hospital today numbers 112 which is almost double what it was five years ago. This has been necessary to meet the demands of increased services to patients and to train specialists in the various fields of medicine.

Dr. Chapin Added to Staff.

Dr. W. E. Chapin, Richmond, has been added to the staff of the State Health Department's Bureau of Maternal and Child Health as pediatrician.

Mary Harley Infirmary.

Upon request of the alumnae and friends, the Board of Overseers of Sweet Briar College has approved the name of Mary Harley Infirmary for the college infirmary, in honor of Dr. Harley, its first physician, who was largely instrumental in raising funds for establishing it. The present infirmary now contains twenty beds and is well equipped.

Dr. Harley was a member of the faculty when the college opened in 1906 and remained with it until her retirement in 1936. Since then she has pursued her study of anthropology in Hawaii, South Africa, at the Museum of Natural History in New York, and at the University of Virginia, but maintains her interest in the infirmary she established.

University of Virginia School of Medcine.

On October 3rd, Dr. Manfred W. Comfort of the Mayo Clinic spoke to the faculty and student body on the subject of "Pancreatitis".

On November 14th, Dr. Paul B. Magnuson, Professor of Surgery, School of Medicine, Northwestern University, gave the first annual lecture under the Charles Venable Lectureship on Traumatic Surgery. Dr. Magnuson spoke on the subject of "Backache and Disc Symptoms: So Confusing".

On November 17th, Dr. Philip S. Hench of the Mayo Clinic, gave the annual Alpha Omega Alpha address. Dr. Hench spoke on "Walter Reed and the Conquest of Yellow Fever".

On November 6th, Dr. H. B. Mulholland, Professor of Practice of Medicine, spoke at the Post Graduate Seminar of the Medical College of the State of South Carolina, Charleston, S. C. on the subject of "Recent Advances in the Treatment of Diabetes Mellitus".

The Ciba Pharmaceutical Company has given a grant of $2500 for investigation in the field of Bacterial Allergy. This investigation will be conducted in the Department of Internal Medicine under the supervision of Dr. Oscar Swineford, Professor of Practice of Medicine.

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Post-Graduate Assembly.

The Fulton County Medical Society announces a three-day Post Graduate Assembly to be held in Atlanta, January 28, 29 and 30, 1948, immediately following the Regional Meeting of the College of Surgeons. Because of the College of Surgeons meeting, surgical subjects will not be emphasized in this Assembly. The program has been arranged to help the average doctor keep abreast of the newer developments, but it is believed it will offer something of value to every man and woman practising medicine in the Southeast.

The College of Surgeons invites all physicians in this region to their meeting, the expenses of which will be met by the College. The Post Graduate Assembly will have to require a registration fee.

For further information, write the Fulton County Medical Society, 875 West Peachtree Street, Northeast, Atlanta, Georgia.

The Southeastern Surgical Congress

Will hold its sixteenth annual assembly at the Hollywood Beach Hotel, Hollywood, Florida, April 5-8, 1948. Among those on the program are Drs. Julian L. Rawls, Norfolk, and J. W. Devine, Jr., Lynchburg.

Dr. Philip E. Rossiter,

Recently with the Veterans Hospital in Canandaigua, is now located in Avon, New York, where he is engaged in general practice and geriatrics.

A Course in Clinical Electrocardiography

Will be presented under the auspices of the Department of Continuation Education, at the Medical College of Virginia every Friday from 2:00—4:00 p. m., beginning on December 5, 1947 and continuing for four months. The presentations will be informal and free discussions, and interpretations of abnormal tracings will be presented. The fee will be on the basis of $5.00 per month.

For participation in this course, application should be made to the Department of Continuation Education, Medical College of Virginia.

The Council on Industrial Health

Of the American Medical Association will hold its Eighth Annual Congress in the Cleveland Auditorium, Cleveland, on January 5 and 6, 1948. These dates immediately precede the Interim Session of the American Medical Association, which will be held in the Auditorium on January 7 and 8. General practitioners supply a large part of the medical services which workers receive through industry, and they are cordially invited to attend these industrial health sessions. The program of the Congress is being constructed with general practitioners in mind and will include discussions of first aid and emergency services in industry, physical examinations, administrative practices, applied physiology, aviation medicine, radiation medicine and practical expositions of occupational disease management, traumatic surgery and rehabilitation. Since full use of medical services in industry depends on support from management and the worker, the essential relationships will be discussed. Industry needs medicine as a practical ally and to promote human relations. The Industrial Health Congresses are intended to further these objectives.

The Jefferson Medical College.

The Annual Lecture given by the Epsilon Chapter of the Alpha Kappa Kappa Fraternity, in memory of Dr. George A. Ulrich, Clinical Professor of Obstetrics of The Jefferson Medical College, Philadelphia, was held on October 20th. The Lecturer was Andrew Conway Ivy, Ph. D., M.D., Distinguished Professor of Physiology in the Graduate School and Vice President in charge of the Chicago Professional Colleges, of the University of Illinois, Department of Medicine. His subject was "Experiments in Resuscitation from Asphyxia."

Married.

Dr. Norman Sollod, Richmond, and Miss Phyllis Laurel Freed, Harrisonburg, November 2nd. Dr. Sollod is a graduate of the Medical College of Virginia, class of '39.

Dr. J. Frasia Jones, Jr., and Miss Henrietta Short Tabb, both of Richmond, November 8th. Dr. Jones is a graduate of the Medical College of Virginia in 1944.

Dr. Henry Carl Messerschmidt, Jr., Richmond, and Miss Betty Rowland Fidler, Burlington, N. C., November 15th. He is a graduate of the Medical College of Virginia in 1946. They will make their home in Bethesda, Maryland.

Dr. Robert C. Kirkwood, Hampton, and Miss Ruth A. L. Dorsey, New York, N. Y., October 1947. Mrs. Kirkwood is emeritus dean of women

of the Drexel Institute of Technology in Philadelphia.

International College of Surgeons.

At the Twelfth Assembly and Convocation of the United States Chapter, International College of Surgeons, held in Chicago on October 3, the following were among the 810 surgeons inducted into the College:

Fellows:

Dr. George W. Botts ----------Norton
Dr. George S. Bourne ----------Roanoke

Associate:

Dr. Mallory Sinclair Andrews ------Norfolk

Dr. Dawson Promoted.

Dr. A. Ray Dawson, who has been chief of the Veterans' Administration Rehabilitation Service at Richmond, has been named as Chief of the Physical Medicine Rehabilitation Service with headquarters in Washington, D. C.

Dr. Carolyn McCue

Richmond, has been named clinical director of the rheumatic fever clinic sponsored jointly by the State Department of Health and the Medical College of Virginia. She succeeds Dr. Louise Galvin, now director of the Health Department Bureau of Crippled Children.

Orthopedic Clinics Sponsored by State Health Department.

The Crippled Children's Bureau sponsors clinics situated at strategic points throughout the state. The services of orthopedic surgeons, who are members of the State Orthopedic Society, are utilized in the conduct of these clinics as clinicians. Local health departments are responsible for organizing and conducting follow-up of the patients as outlined by the orthopedist. Only such patients are eligible for these clinics on whom the expense of taking care of their condition would produce a hardship financially. Those who can afford to pay for medical care are not eligible for this service.

The Crippled Children's Bureau will provide hospitalization for these clinic patients where the clinician makes his diagnosis and recommends that hospitalization be taken care of under the plan of the Crippled Children's Bureau. The orthopedic clinicians know the requirements for utilizing this plan.

The tentative schedule for the first six months of 1948 is as follows:

Arlington—Every Tuesday and Thursday.
Boydton—4th Tuesday—March, June.
Bristol—2nd Wednesday—January, March, May.
Chatham—3rd Thursday—February, May.
Courtland—4th Tuesday—January, March, May.
Covington—3rd Thursday—June.
Emporia—4th Tuesday—January, March, May.
Farmville—3rd Thursday Monthly.
Fredericksburg—2nd Saturday—March, June.
Hampton—3rd Friday Monthly.
Harrisonburg—2nd Saturday—March, June.
Lawrenceville—4th Tuesday—March, June.
Lebanon—2nd Wednesday—February, June.
Lexington—4th Tuesday—January, April.
Luray—3rd Wednesday—March.
Lynchburg—1st Friday Monthly.
Norton—2nd Wednesday—April.
South Boston—4th Friday—January, May.
Suffolk—3rd Tuesday Monthly.
Portsmouth—1st Tuesday Monthly.
Winchester—2nd Friday and Saturday—February, May.
Woodstock—3rd Wednesday—March.
Richmond—4th Sunday—January, April.
Roanoke—2nd Thursday Monthly.
Bedford—2nd Friday—April.

There are other clinics that are scheduled by mutual agreement between the Crippled Children's Bureau and the clinician, usually two a year. This schedule is subject to some variation where, for the sake of expediency, the clinician and the director of the Crippled Children's Bureau agree.

Midwinter Seminar in Otolaryngology and Ophthalmology.

This year the University of Florida Midwinter Seminar in Otolaryngology and Ophthalmology will be held at the Flamingo Hotel in Miami Beach, beginning on January 12 and continuing through January 17, 1948. The lectures in Otolaryngology will be presented on the 12th, 13th and 14th, and those in Ophthalmology on the 15th, 16th and 17th. The registration fee is $25.

The distinguished lecturers for the courses in Otolaryngology include Drs. Lawrence R. Boies, Minneapolis; Louis H. Clerf, Philadelphia; Kenneth M. Day, Pittsburg; Thomas C. Galloway, Chicago; James H. Maxwell, Ann Arbor, Mich.; Arthur W. Proetz, St. Louis; and Harry P. Schenck, Philadelphia. Among the outstanding ophthalmologists who will lecture are Drs. S. Judd Beach, Portland, Me.; William L. Benedict, Rochester,

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Minn.; Daniel B. Kirby, New York; Peter C. Kronfeld, Chicago; and Dohrmann K. Pischel, San Francisco.

The Midwinter Seminar follows immediately the Pan-American Congress of Ophthalmology, which will be held in Havana, Cuba, January 5-10, 1948. The dates chosen for the two meetings make possible a delightful opportunity to attend both and at the same time enjoy a winter vacation amid unsurpassed resort attractions.

Christmas Is Again Around the Corner.

Do you want to celebrate this Christmas in the true holiday spirit? Then invite a hungry European family to dinner as your guests during the holiday week. Invite them in your name . . . or invite them in the name of a friend.

No, they won't be able to come in person, but you can send them *Care* Food Packages—enough in each package to feed supplementary meals to a family of four for a full month. Or you can send any of the other famous *Care* packages . . . Baby Food, Infant Food, Blanket, Cotton, Woolen, Knitting Wool, Household Linen, Layette . . . all so desperately needed in Europe today.

Care will send a handsome Donor Certificate to anyone you designate, informing them that you have sent a *Care* food package to a needy European family in their name.

Just send your order, with $10, plus the name and address of the person to which you wish the Donor Certificate sent, to *Care*, 50 Broad Street, New York 4, N. Y.

Gastroenterological Award Contest.

The National Gastroenterological Association has announced its Annual Cash Prize Award Contest for 1948. One hundred dollars and a Certificate of Merit will be given for the best unpublished contribution on Gastroenterology or allied subjects. Contestants residing in the United States must be members of the American Medical Association. The winning contribution will be selected by a board of impartial judges and the award is to be made at the Annual Convention Banquet of the National Gastroenterological Association in June of 1948.

All entries for the 1948 prize should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies, accompanied by an entry letter, and must be received not later than April 1, 1948. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

Dr. E. G. Gill,

Roanoke, has been appointed by Dr. Thomas E. Hughes, immediate past president of the Virginia Society of Ophthalmology and Otolaryngology, to represent this Society at the Third Pan-American Congress of Ophthalmology to be held in Havana, Cuba, January 4 to 10, 1948. Dr. Gill is also reading a paper at this meeting on "Recent Advances in Intracapsular Cataract Surgery".

Dr. J. T. Showalter,

Class of '36, University of Virginia, who has been taking special work at Philadelphia Hospitals for the past year, has now located in Christiansburg where he is engaged in general medicine and surgery at the New Altamont Hospital with Drs. A. M. Showalter, R. H. Grubbs and George M. Caldwell.

The Southeastern Allergy Association

Will hold its third annual meeting in Richmond, January 17 and 18, under the presidency of Dr. J. Warrick Thomas of this city. Headquarters will be at the Jefferson Hotel. Further information may be obtained from Dr. Thomas or the secretary, Dr. Katharine B. MacInnis, Columbia, S. C.

Dr. Linwood D. Keyser,

Roanoke, was one of the guest speakers at the 17th Annual Fall meeting of the Oklahoma City Medical Conference. He addressed the Conference on "Endocrinology of the Prostate" and on "Noncalculous Pain Syndromes in the Urinary Tract".

For Sale.

McCarthy Pan-Endoscope and McCarthy Visual Prostatic Electrotome. Used very little and as good as new. Write "McCarthy" care of this Journal. (*Adv.*)

For Rent.

New completely furnished office in Richmond for young practitioner. Available immediately. Write "Office" care the Monthly, 1200 East Clay Street, Richmond 19, Virginia. (*Adv.*)

For Sale.

Maico audiometer three years old, in perfect condition, complete with air conductor, bone conductor, malingering and loudness balance. If interested please write to Suite 46, 1746 K Street, N. W., Washington 6, D. C. (*Adv.*)

OBITUARIES

Dr. Charles Cheves Haskell,

Well known Richmond physician and, since 1937, president of Charles C. Haskell & Company, Richmond, died November 12, at his home, after a brief illness.

Dr. Haskell was born March 29, 1880, in Columbia, S. C., and was a son of the late John Cheves Haskell and Sarah Hampton Haskell. He was a grandson of General Wade Hampton, C.S.A.

After graduating from the University of Virginia, Dr. Haskell attended Harvard University and received his M.D. degree from that institution in 1908. He came to Richmond in 1913 where he practiced medicine and taught in the department of physiology and pharmacology of the Medical College of Virginia. In 1916 he was made head of the department, a position which he held with distinction until he resigned in 1929 to become medical director of Ciba Pharmaceutical Company, Summit, N. J. In 1937 he returned to Richmond and founded here the Charles C. Haskell Company, manufacturers of prescription pharmaceuticals, of which he continued to be president until his death.

Dr. Haskell was an outstanding teacher and investigator. Although the research facilities at the College were rather meager at the time he was teaching there, he kept the flame of research burning brightly in his department and carried out investigations on the pharmacology of digitalis, which gave him world-wide recognition and placed him as one of the most outstanding investigators in that field. Probably no piece of investigation portrays more his unselfish devotion to science than a piece of work which he carried out, with the cooperation of Dr. E. C. L. Miller, during the First World War. Since it was rumored at the time that German saboteurs were adding ground glass to flour, they ate ground glass and showed that it caused no ill effects.

He was also interested in the therapeutic approach to the treatment of mercury poisoning and made important contributions to that subject. Truly, it can be said of him that his spirit liveth in the hearts and minds of all who were privileged to know him.

He was a member of the Richmond Academy of Medicine, the Medical Society of Virginia and a Fellow of the American Medical Association.

Surviving are his wife, the former Miss Marie Graham, of Boston, Massachusetts, one daughter, Miss Margaret Graham Haskell; one brother, Frank Hampton Haskell, of Columbia, S. C., and several nieces and nephews.

Dr. Bernard Heath Early,

For many years a practicing physician at Esmont, died at the home of his daughter in New Orleans on November 10th. He was seventy years of age and a graduate of the former University College of Medicine, Richmond, in 1898. Dr. Early had retired from active practice several years ago due to ill health. He had been a member of the Medical Society of Virginia for forty-seven years.

Dr. Joseph Grice,

Prominent physician of Portsmouth, died October 21st. He was seventy-eight years of age and graduated in medicine from the University of Virginia in 1893. Dr. Grice was the first bacteriologist of Portsmouth and was for a time the city school physician. He was a small boat enthusiast and organized the Portsmouth boat club. Dr. Grice had been a member of the Medical Society of Virginia for fifty-one years.

Dr. Claude Gibson Hooten,

Lynchburg, died July 25 of heart disease. He was fifty-six years of age and a graduate of Bennett Medical College, Chicago, in 1915. He saw service in World War I and was for a number of years a medical examiner for the Norfolk and Western Railway. Dr. Hooten was a member of his local and State Medical Societies and also of the American Medical Association.

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